

Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

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Preface

Among the many contributors to health inequities, the lack of culturally and linguistically appropriate services in health settings has been recognized as one of the more modifiable factors. Improving the availability of such services will not only improve the quality of care provided, but it may also reduce disparities experienced by racial and ethnic minorities and other underserved populations who face language, literacy, or other cultural barriers. To provide meaningful and practical guidance on delivering culturally and linguistically appropriate services to health organizations and health care organizations (HCOs), the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH), in collaboration with federal and nonfederal partners across the country, developed the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The National CLAS Standards, which are targeted toward health organizations and HCOs, were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing landscape with respect to new national policies and legislation, including the Affordable Care Act. Central to this effort was the recognition of the need for a long-term evaluation framework for assessing the implementation of the National CLAS Standards.

RAND was awarded a contract by HHS OMH to develop the long-term evaluation framework for the National CLAS Standards. This report presents the details of the development of the framework, while the accompanying RAND toolkit titled *Evaluation of the National CLAS Standards: Tips and Resources* (PR-3599-DHHS/OMH, Williams et al., 2018) distills the elements of the framework and is intended to help guide the efforts of HCOs to evaluate the implementation of the National CLAS Standards across four settings: ambulatory care, behavioral health, hospitals, and public health.

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This work was sponsored by HHS OMH under contract No. HHSP233201500038I. The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

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Contents

Preface.....	iii
Figures.....	vi
Tables.....	vii
Summary.....	viii
Acknowledgments.....	xvii
Abbreviations.....	xviii
Chapter One. Introduction	1
The National CLAS Standards.....	2
Governance, Leadership, and Workforce.....	2
Communication and Language Assistance	2
Engagement, Continuous Improvement, and Accountability	2
Project Goals	3
Approach	4
Technical Advisory Group.....	4
Development of the Conceptual Framework and Logic Models	4
Development of Evaluation Questions and Measures	5
Organization of This Report.....	5
Chapter Two. Conceptual Framework.....	7
Diffusion Within the Health Organization	8
Antecedents and Inputs	8
Readiness for the National CLAS Standards	9
Development of Implementation Strategies and Communication	10
Adoption/Implementation	11
Outputs and Outcomes	12
Quality Improvement	13
Linkages with the Community and Other Stakeholders.....	13
Environmental and Policy Context	14
Conclusion.....	15
Chapter Three. Ambulatory Care Logic Model.....	16
Logic Model for Implementing the National CLAS Standards Within the Ambulatory Care Setting ...	18
Context, Antecedents, and Inputs.....	18
National CLAS Standards	22
Proposed Changes and Strategies Developed to Implement Those Changes	22
Outputs	23
Outcomes.....	24
Quality Improvement	25
Chapter Four. Hospital Logic Model.....	26

Logic Model for Implementation of the National CLAS Standards Within the Hospital Setting	28
Context, Antecedents, and Inputs.....	28
National CLAS Standards	32
Proposed Changes and Strategies Developed to Implement Those Changes	32
Outputs	33
Outcomes.....	33
Quality Improvement	34
Chapter Five. Behavioral Health Logic Model.....	35
Logic Model for Implementation of the National CLAS Standards Within the Behavioral Health	
Setting.....	36
Context, Antecedents, and Inputs.....	36
National CLAS Standards	41
Proposed Changes and Strategies Developed to Implement Those Changes	41
Outputs	41
Outcomes.....	42
Quality Improvement	43
Chapter Six. Public Health Logic Model.....	44
Logic Model for Implementation of the National CLAS Standards Within the Public Health	
Setting.....	45
Context, Antecedents, and Inputs.....	47
National CLAS Standards	50
Proposed Changes and Strategies Developed to Implement Those Changes	50
Outputs	51
Outcomes.....	51
Quality Improvement	52
Chapter Seven. Evaluation Questions and Impact Measures.....	54
Evaluation Questions.....	55
Process Evaluation Questions	56
Outcomes Evaluation Questions	57
Measures.....	59
Approach.....	59
Measures Identified.....	60
Chapter Eight. Conclusions	67
Appendix A. List of Technical Advisory Group Members	69
Appendix B. Cross-Cutting Measures	70
Appendix C. Ambulatory Care Measures	83
Appendix D. Hospital Measures	88
Appendix E. Behavioral Health Measures	97
Appendix F. Public Health Measures	101
References.....	108

Figures

Figure S.1. Conceptual Framework for Evaluating the National CLAS Standards.....	x
Figure S.2. Logic Model for Implementation of the National CLAS Standards Within the Ambulatory Care Setting	xi
Figure 2.1. Conceptual Framework for the Diffusion of the National CLAS Standards.....	8
Figure 3.1. Logic Model for Implementation of the National CLAS Standards Within the Ambulatory Care Setting	19
Figure 4.1. Logic Model for Implementation of the National CLAS Standards Within the Hospital Setting.....	30
Figure 5.1. Logic Model for Implementation of the National CLAS Standards Within the Behavioral Health Setting	38
Figure 6.1. Logic Model for Implementation of the National CLAS Standards Within the Public Health Setting	46

Tables

Table S.1. Cross-Cutting Measures	xv
Table 6.1. Linking the National CLAS Standards to Core Public Health Department Functions	44
Table 6.2. Diverse LHD Organizational Arrangements	45
Table 7.1. Cross-Cutting Measures.....	61
Table 7.2. Ambulatory Care Measures	62
Table 7.3. Hospital Measures.....	63
Table 7.4. Behavioral Health Measures	65
Table 7.5. Public Health Measures	66
Table B.1. Cross-Cutting Measures	71
Table B.2. Cross-Cutting Measures: Additional Details	73
Table C.1. Ambulatory Care Measures.....	83
Table C.2. Ambulatory Care Measures: Additional Details	86
Table D.1. Hospital Measures.....	88
Table D.2. Hospital Measures: Additional Details	92
Table E.1. Behavioral Health Measures	97
Table E.2. Behavioral Health Measures: Additional Details	99
Table F.1. Public Health Measures	101
Table F.2. Public Health Measures: Additional Details	104

Summary

Among the many contributors to health inequities, the lack of culturally and linguistically appropriate services in health settings has been recognized as one of the more modifiable factors. Improving the availability of such services will not only improve the quality of care provided, but it may also reduce disparities experienced by racial and ethnic minorities and other underserved populations who face language, literacy, or other cultural barriers (Saha, Beach, and Cooper, 2008). To provide meaningful and practical guidance on delivering culturally and linguistically appropriate services, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH), in collaboration with federal and nonfederal partners across the country, developed the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The National CLAS Standards, which are targeted toward health organizations and health care organizations (HCOs), were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing landscape with respect to new national policies and legislation, including the Affordable Care Act (ACA) (HHS OMH, 2013). Central to this effort was the recognition of the need for a long-term evaluation framework for health organizations and HCOs that are implementing the National CLAS Standards. The evaluation framework was designed to provide a systematic approach to gathering data to evaluate the effectiveness of the National CLAS Standards through three key objectives: (1) describing the National CLAS Standards theory of change, (2) developing evaluation questions that test the theory of change and their corresponding methods, and (3) developing indicators and supporting data metrics to support the National CLAS Standards theory of change.¹

The RAND Corporation was awarded a contract by HHS OMH to develop a long-term evaluation framework for the National CLAS Standards to help health organizations and HCOs assess the impact that implementation of the National CLAS Standards has both on the quality of care and services provided and on patient outcomes. RAND convened a technical advisory group (TAG) to inform the development of key elements of this evaluation framework, including an overarching conceptual framework and setting-specific logic models, evaluation questions, and process and impact measures.

¹ The terms *indicators* and *measures* can be used interchangeably. In this report, we chose to use the term *measure* to be inclusive of the wide range of different types of measures, from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to such disparity-sensitive clinical measures as median time to electrocardiogram (ECG).

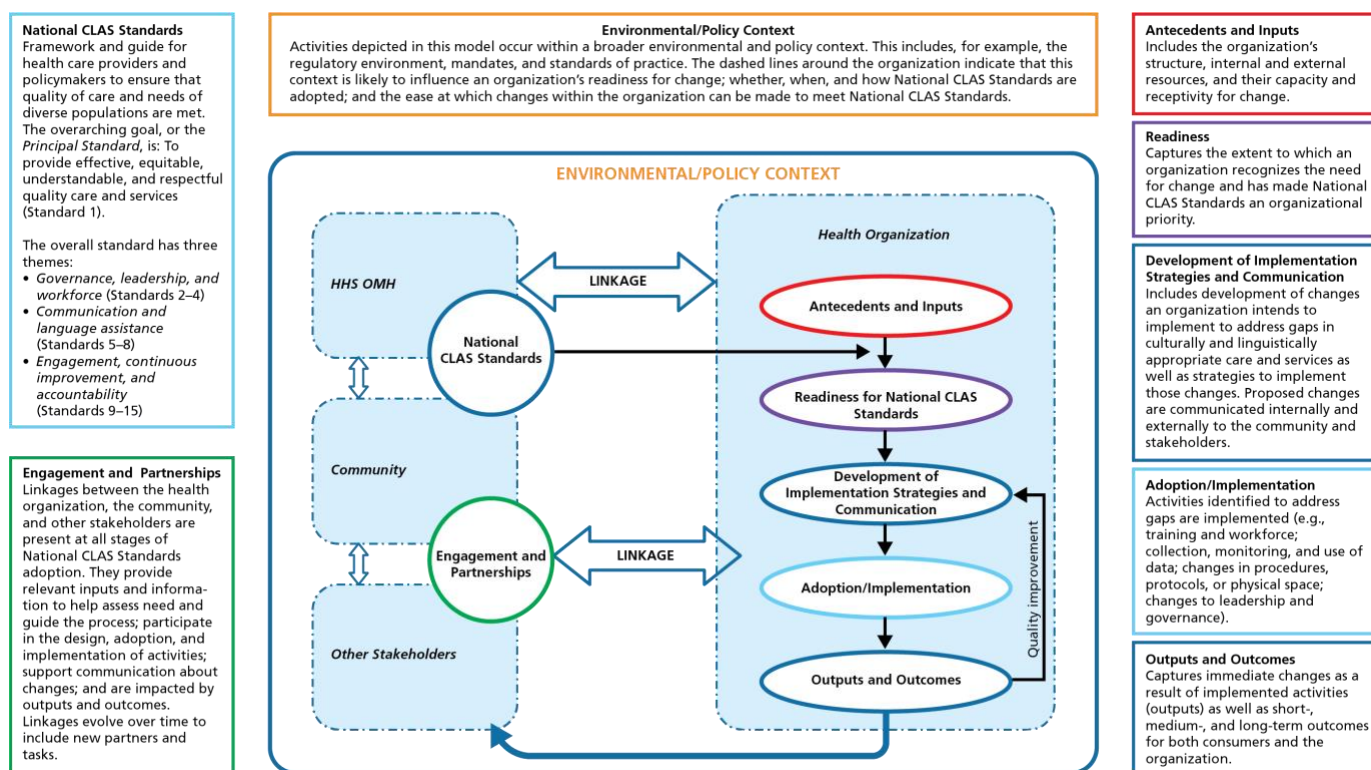
Conceptual Framework for Evaluating the National CLAS Standards

In the conceptual framework shown in Figure S.1, the National CLAS Standards represent the innovation to be adopted by a health organization. Although the National CLAS Standards were published by HHS OMH, they were developed in conjunction with a wide range of community stakeholders. These stakeholders and community members have witnessed or experienced situations in which culturally and linguistically appropriate care and services were not present, provided feedback and input on current gaps, and helped inform and shape a set of National CLAS Standards that addressed many of these concerns.

Whether and how readily an organization is willing and able to adopt the National CLAS Standards depend on a number of factors relevant to the National CLAS Standards themselves. These factors include the organization's understanding of the National CLAS Standards, the availability of guidelines and examples of best practices, and the perceived relative advantage to the organization of implementing the National CLAS Standards. Organizations will also assess how compatible the National CLAS Standards are with current organizational goals, practices, and other regulations or guidelines they must follow, as well as how easy or hard they are to understand and adopt into practice.

The conceptual framework shown in Figure S.1 describes the diffusion of the National CLAS Standards within a given health organization, including organization-specific antecedents and inputs; readiness for adopting the National CLAS Standards; activities related to the adoption, assimilation, and diffusion of the National CLAS Standards, such as strategies for implementation; and communication about those activities, the implementation of the activities, and outputs and outcomes for both internal and external audiences.

Figure S.1. Conceptual Framework for Evaluating the National CLAS Standards

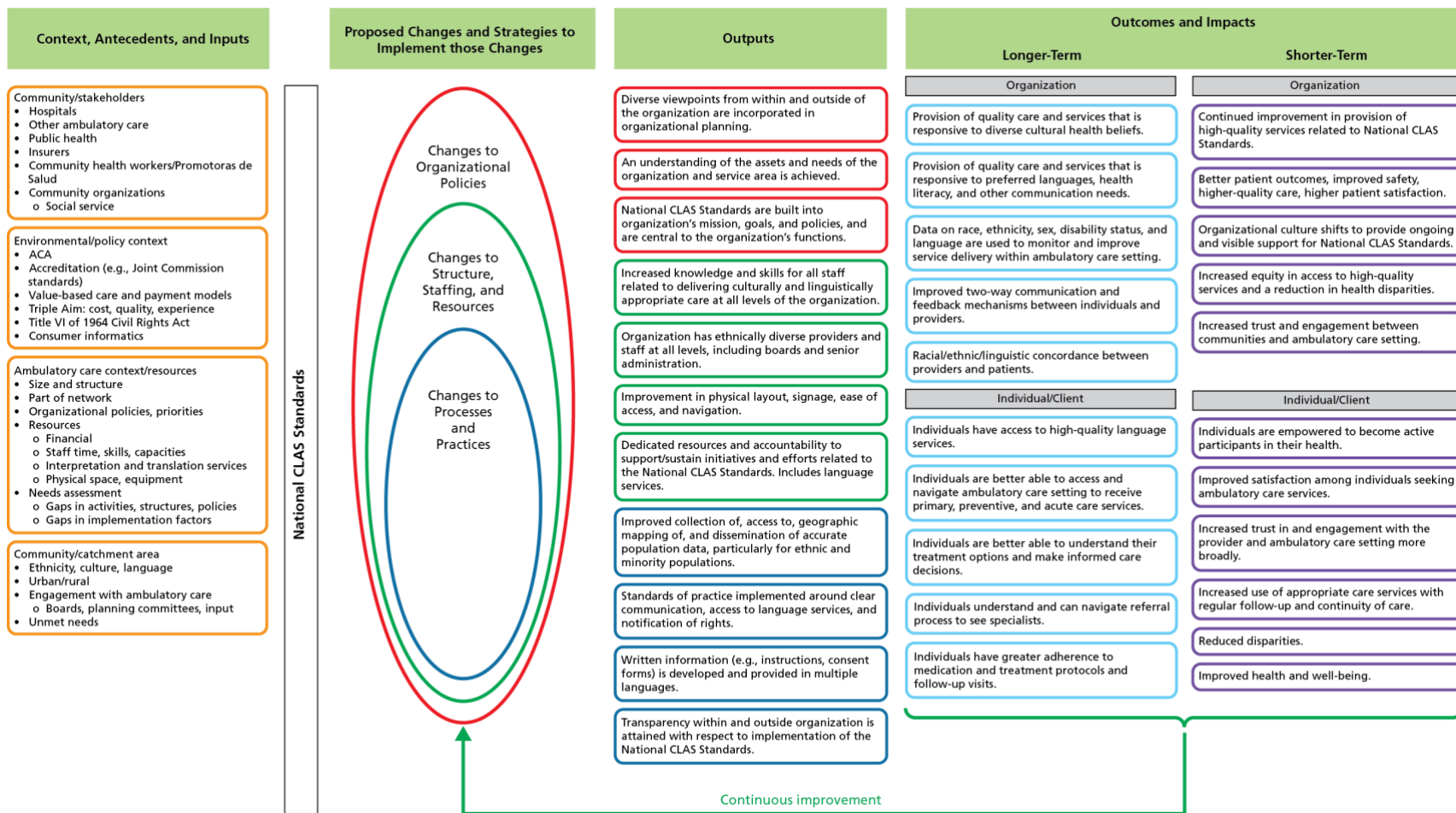


RAND RR2157-S.1

Setting-Specific Logic Models

Based on the conceptual framework, we developed logic models for the four settings that are the focus of this study: ambulatory care, hospitals, behavioral health, and public health. The logic model for ambulatory care is illustrated in Figure S.2. For each logic model, we first discuss the relevance of the National CLAS Standards to each setting, including relevant linkages with the community and other stakeholders. The logic model itself includes the context, antecedents, and inputs; proposed changes and strategies to implement those changes; outputs; and short-term and longer-term outcomes at the organizational and client levels. We also depict the adoption and implementation of the National CLAS Standards as a continual process, requiring a quality improvement (QI) loop in which outputs and outcomes inform the development of future ambulatory care settings (ACS) actions, policies, or programs to better align with the National CLAS Standards.

Figure S.2. Logic Model for Implementation of the National CLAS Standards Within the Ambulatory Care Setting



RAND RR2157-S.2

Evaluation Questions

We derived evaluation questions from the conceptual framework and logic models that address the process of an organization deciding to implement the National CLAS Standards, the planning for and implementation of activities to do so, and the resulting outputs, as well as key outcomes to measure. We identified the overarching process and outcomes evaluation questions and detailed a subset of related questions for each overarching question.

The overarching process evaluation questions include:

1. Is there an awareness of the National CLAS Standards?
2. Does the organization have a team tasked with addressing culture and language?
3. Does the organization have active and ongoing input from the community?
4. Has the organization completed a needs assessment with respect to the National CLAS Standards?
5. Has the organization developed an implementation plan to address identified gaps and priorities?
6. Has the organization committed funds or resources for the proposed change?
7. To what extent has the organization implemented its plan to address identified needs and gaps in culturally and linguistically appropriate services?
8. To what extent does the organization collect and use data for continuous quality improvement (CQI)?

The overarching outcomes evaluation questions are grouped by short-term and longer-term outcomes.

Short-Term Outcomes

For organizations: To what extent has the implementation of the National CLAS Standards led or contributed to

- use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve health service delivery?
- improved two-way communication between providers and clients?
- increased knowledge of culturally and linguistically appropriate care and buy-in from staff?
- better and earlier detection of health care concerns through appropriate screening?

For clients or individuals: To what extent has the implementation of the National CLAS Standards resulted in

- improved access to high-quality language services for ethnic and minority populations?
- consumers being better able to access and navigate health care services? If so, in what ways?
- increased consumer understanding of health care treatment options and to more-informed care decisions?
- greater adherence to medication, treatment protocols, and follow-up visits?

Longer-Term Outcomes

For organizations: To what extent has the implementation of the National CLAS Standards led to a cultural shift in the organization? To what extent has implementation led to or contributed to

- improvements in the provision of high-quality services for diverse populations?
- improved health outcomes for ethnic and minority populations?
- increased trust and engagement between patients and providers?
- increased trust and engagement between the community and HCOs?
- increased equity in access to health services?
- reductions in disparities in health outcomes?
- increased capacity of the HCO or health system to address the needs of a diverse population?

For clients or individuals: To what extent has the implementation of the National CLAS Standards led to

- individuals feeling empowered to become active participants in their health care?
- improved satisfaction among individuals seeking health care?
- increased trust and engagement between individuals seeking care and treatment providers?

To what extent has implementation contributed to

- increased use of appropriate health care services with regular follow-up and continuing of care?
- increased equity in outcomes of health services?
- improved health, family, and social functioning and overall well-being?

Measures

The overarching goal of the National CLAS Standards is to “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” (Principal Standard [Standard 1] in HHS OMH, 2013). It is important to place the National CLAS Standards in the context of ongoing trends in the health care field. Increasing emphasis on outcomes of care, patient experience, and value-based care, along with increasingly diverse patient populations, mean that for most HCOs, examining quality scores for their overall population served will no longer be sufficient. HCOs will also need to assess whether and how those quality scores differ between patients or clients belonging to different racial/ethnic groups or different language groups. Ideally, where gaps are found, HCOs will develop QI interventions to reduce gaps and track improvements over time.

As such, our emphasis was on salient measures that can be quantified, compared between patient and client subgroups, and/or compared over time. Most of the identified measures are

based on survey questions, such as CAHPS survey items, or on electronic medical records (EMRs) and claims data. Each HCO may differ with respect to the type of measure or measures that are most applicable and useful to its CLAS efforts.

Our goal was to identify a range of examples for each health care setting, emphasizing well-constructed and validated measures with some or all of the following characteristics:

- assessed cultural competency
- captured language needs or preferences and/or were linked to other CLAS-related issues
- documented disparities
- were widely used and plausible for use in a range of HCOs (e.g., small or large)
 - were inclusive of measures that are used by several different quality reporting systems (e.g., sets of measures used by the Health Resources and Services Administration, National Committee for Quality Assurance, and Centers for Medicare & Medicaid Services [CMS])
- were previously endorsed in commissioned projects or reports for evaluating disparities
- were validated and/or psychometrically tested
- include cross-cutting measures across conditions and/or across settings.

Although we included some process measures, our focus was on identifying outcome and impact measures relevant to evaluating the implementation of the National CLAS Standards. Wherever possible, we also sought to identify measures of short-term or intermediate outcomes of health care encounters with the HCO to facilitate more-rapid feedback on whether the CLAS-related policies and practices put in place have helped to achieve the desired outcomes. This includes, for example, clinical outcomes, such as blood pressure control, or a patient's reported experience with care, such as whether the patient felt that he or she was treated unfairly at the provider's office because of cultural (e.g., sexual orientation or gender identity, immigrant status, race) or language differences. In addition, we sought to identify examples of disparity-sensitive measures for each setting that might help an HCO assess how well it is doing in addressing identified disparities in outcomes. Rather than being comprehensive, the set of measures identified is intended to illustrate which key outcome and impact measures are salient to the National CLAS Standards. The measures are categorized as cross-cutting (i.e., measures that are applicable to a range of settings) and setting-specific for ambulatory care, hospitals, behavioral health, and public health.

Table S.1 provides a summary of the cross-cutting measures identified. The setting-specific measures are provided in Chapter Seven.

Table S.1. Cross-Cutting Measures

Measure(s)	Description
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of a provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician/Group Survey. The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Patients receiving language services supported by qualified language services providers	This measure is used to assess the percentage of patients with limited English proficiency receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees during critical times in a patient's health care experience.
Screening for preferred spoken language for health care	This measure is used to assess the percentage of patient visits and admissions in which the preferred spoken language for health care is screened and recorded. This measure provides information on the extent to which patients are asked about the language in which they prefer to receive care and the extent to which this information is recorded.
Cultural Competency Implementation Measure	The Cultural Competency Implementation Measure is an organizational survey designed to assist HCOs in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 National Quality Forum–endorsed cultural competency practices prioritized for the survey. Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.

Measure(s)	Description
Communication Climate Assessment Toolkit (C-CAT)	C-CAT, which has been extensively validated in diverse HCOs nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices. When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment, conduct statistical analysis of data (including comparisons against a national benchmarking database), and create a feedback report featuring personalized, site-specific recommendations. In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it complements CAHPS assessments, documents compliance with Title VI (CLAS) standards, and is invaluable in meeting the patient-centered communication standards of the Joint Commission on Accreditation of Healthcare Organizations.

Conclusions

The National CLAS Standards call attention to 15 areas that, if addressed, hold great promise for helping health organizations and HCOs address current barriers to providing equitable care. The OMH also recognized the importance of establishing an evaluation framework to guide long-term efforts to assess the implementation of the National CLAS Standards. The evaluation framework, logic models, and evaluation questions and measures presented in this report are intended to provide a systematic approach for gathering data to evaluate the effectiveness of the National CLAS Standards.

In addition, we have developed a companion toolkit titled *Evaluation of the National CLAS Standards: Tips and Resources* (Williams et al., forthcoming). The interactive toolkit is designed to support health organizations in their efforts to implement the National CLAS Standards and to improve their capacity to evaluate their approach. By providing a conceptual framework and logic models, evaluation questions, and measures that are already widely collected in practice, health organizations can more easily assess the impact of their efforts, both on the individuals they serve and on their organizations. Such evaluations can not only provide valuable data and insights that inform CQI efforts within a given health organization but collectively can inform and help to shape systems-level change toward providing culturally and linguistically appropriate care and services.

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- Tawara D. Goode, M.A., assistant professor and director, Georgetown University National Center for Cultural Competence and Center for Child and Human Development
- LaMar Hasbrouck, M.D., M.P.H., executive director, National Association of County and City Health Officials
- Cara James, Ph.D., director, Office of Minority Health, CMS
- Rodrigo Monterrey, acting director, Massachusetts Department of Public Health, Office of Health Equity
- Roslyn Holliday Moore, M.S., senior policy analyst, Office of Behavioral Health Equity, Substance Abuse and Mental Health Services Administration
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Abbreviations

ACA	Affordable Care Act
ACO	accountable care organization
ACS	ambulatory care setting
AHA	American Hospital Association
AHCM	Accountable Health Communities Model
AHRQ	Agency for Healthcare Research and Quality
AMI	acute myocardial infarction
APA	American Psychological Association
CABG	coronary artery bypass graft
CAHPS	Consumer Assessment of Healthcare Providers and Systems
C-CAT	Communication Climate Assessment Toolkit
CCATH	Cultural Competency Assessment Tool for Hospitals
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CHNA	community health needs assessment
CLAS	culturally and linguistically appropriate services
CMS	Centers for Medicare & Medicaid Services
COPD	chronic obstructive pulmonary disease
CQI	continuous quality improvement
EMR	electronic medical record
FQHC	Federally Qualified Health Center
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCO	health care organization
HEDIS	Healthcare Effectiveness Data and Information Set
HF	heart failure
HHS	U.S. Department of Health and Human Services

HIT	health information technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HRSA	Health Resources and Services Administration
IFD	Institute for Diversity in Health Management
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	limited English proficiency
LHD	local health department
MBHO	managed behavioral health care organizations
MHPA	Mental Health Parity Act of 1996
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NACCHO	National Association of County and City Health Officials
National CLAS Standards	National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
NCQA	National Committee for Quality Assurance
NIMH	National Institute of Mental Health
OMH	Office of Minority Health
PCI	percutaneous coronary intervention
POA	present on admission
QI	quality improvement
RSRR	risk-standardized readmission rate
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SES	socioeconomic status
SPF	Strategic Prevention Framework
TAG	technical advisory group
THA	total hip arthroplasty
TKA	total knee arthroplasty

Chapter One. Introduction

Cultural competency is achieved through learning processes, structures, and policies by which organizations and individuals develop the attitudes, behaviors, and systems needed for effective cross-cultural interactions, including, but not limited to, such sociocultural factors as race/ethnicity, nationality, language, gender, socioeconomic status (SES), immigrant status, physical and mental ability, sexual orientation, religion, health literacy, age, and occupation (Betancourt et al., 2003). Culture is central in delivering health care services because it can influence patients' health beliefs, medical practices, attitudes toward medical care, and levels of trust (U.S. Department of Health and Human Services [HHS], 2001). Cultural and language differences can affect how health information is received, understood, and acted on (Anderson et al., 2003). Clinical barriers occur when cultural and language differences are not adequately addressed in health care delivery, leading to lower access and quality of care for culturally diverse populations.

“Health equity is the attainment of the highest level of health for all people” (HHS Office of Minority Health [OMH], undated). Health inequities result in disparities that affect quality of life, neighborhoods, communities, and the broader society (HHS OMH, 2013). A number of factors affect health equity, including SES, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, undated), with health inequities being directly related to the existence of historical and current discrimination and social injustice (HHS OMH, 2013). Despite multiple public- and private-sector initiatives to address health inequities and disparities in access to health and health care, progress has been slow, and problems with equity and disparities persist. Among the many factors related to health inequities, a lack of culturally and linguistically appropriate services has been recognized as one of the more modifiable factors (Saha, Beach, and Cooper, 2008). Improving the availability of such services will not only improve the quality of care received but may also reduce the resulting disparities experienced by racial and ethnic minorities and other underserved populations.

To provide meaningful and practical guidance to health organizations and health care organizations (HCOs), HHS OMH, in collaboration with federal and nonfederal partners across the country, developed the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) to provide guidance for delivering culturally and linguistically appropriate services to improve quality, advance health equity, and help eliminate health disparities. The original National CLAS Standards were intended to provide guidance on cultural and linguistic competency, with the goal of ultimately reducing racial and ethnic health care disparities (HHS OMH, 2013). From 2010 to 2012, OMH launched the National CLAS Standards Enhancement Initiative to update and revise the National CLAS Standards to account for the increasing diversity of the U.S. population, the growth in

cultural and linguistic competency fields, and the changing landscape with respect to new national policies and legislation, including the Affordable Care Act (ACA) (HHS OMH, 2013). The resulting 15 National CLAS Standards “are intended to advance health equity, improve quality, and help eliminate health care disparities” (HHS OMH, 2013).

The National CLAS Standards

The essential goal of the National CLAS Standards is framed in the Principal Standard (Standard 1): **Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.**

The remaining 14 National CLAS Standards are listed below and span the themes of governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the populations in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The revised National CLAS Standards incorporated broader definitions of culture and health and were intended to reach a wide audience, with the goal of ensuring that every individual has the opportunity to receive culturally and linguistically appropriate health care and services. Specifically, OMH put forth the following definitions in its 2013 *Blueprint for Advancing and Sustaining CLAS Policy and Practice* (HHS OMH, 2013):

Culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

Health is understood to encompass many aspects, including physical, mental, social, and spiritual well-being (HHS Indian Health Service, undated; HHS Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012; World Health Organization [WHO], 1946). The World Health Organization also notes that health is “not merely the absence of disease or infirmity” (WHO, 1946). Health status occurs along a continuum and therefore can range from poor to excellent. The advancement of health equity allows individuals to experience better health over the course of their life spans.

Audience: The [revised] National CLAS Standards reference both health and health care organizations to acknowledge those working not only in health care settings, such as hospitals, clinics, and community health centers, but also in organizations that provide services such as behavioral and mental health, public health, emergency services, and community health. Any organization addressing individual or community health, health care, or well-being can benefit from the adoption and implementation of the National CLAS Standards.

Project Goals

In its 2013 *Blueprint* (HHS OMH, 2013), OMH recognized that implementation of the National CLAS Standards would vary from HCO to HCO and would depend on the organization's size, mission, scope, and type of services offered. OMH also recognized the need to establish an evaluation framework to guide long-term efforts to assess the implementation of

the National CLAS Standards—to describe the National CLAS Standards’ adoption and implementation and examine the relationship between the National CLAS Standards’ implementation and their associated outcomes, including advancing health equity, improving quality, and eliminating health care disparities. The evaluation framework was created to provide a systematic approach to gathering data to evaluate the effectiveness of the National CLAS Standards through three key objectives: (1) describe the National CLAS Standards theory of change, (2) develop evaluation questions that test the theory of change and the corresponding methods, and (3) develop indicators² and supporting data metrics to support the National CLAS Standards theory of change. In 2016, through a competitive bidding process, OMH awarded the RAND Corporation a contract to develop that evaluation framework.

Approach

Technical Advisory Group

To help guide the development of the evaluation framework, we formed a technical advisory group (TAG). For a full list of TAG members, see Appendix A. The TAG included diverse representation from experts in language and culture, diversity and equity, evaluation, direct service provision, and each of the health care settings prioritized by the project (ambulatory care, hospitals, behavioral health, and public health). In addition, we sought a balance of representatives from federal and nonfederal organizations.

Development of the Conceptual Framework and Logic Models

To develop the conceptual framework, we adapted an existing model by Greenhalgh et al. (2004) that focused on the diffusion of innovations in HCOs. The resulting framework conceptualizes the National CLAS Standards as an innovation to be adopted within health care settings; describes the inputs, activities, outputs, and outcomes occurring within an HCO; and illustrates how the National CLAS Standards may be implemented and adopted.

We then developed setting-specific logic models, drawing from literature reviews as well as feedback from our TAG. Given the wide range of changes that could be made within an HCO in response to implementing the National CLAS Standards, we decided to keep the logic models at a somewhat high level, with the intent that HCOs would use these as a starting point for their own evaluation, providing richer detail specific to their setting.

² The terms *indicators* and *measures* can be used interchangeably. In this report, we chose to use the term *measure* to be inclusive of the wide range of types of measures, from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures to such disparity-sensitive clinical measures as median time to electrocardiogram (ECG).

Development of Evaluation Questions and Measures

The evaluation questions were designed to capture key elements of the logic models and to address both the process of implementing the National CLAS Standards and the relevant outputs and outcomes. The final set of evaluation questions is relevant across a range of HCOs.

To identify the set of process and impact measures, we conducted a review of the literature and reviewed a wide range of existing surveys and data-collection instruments already used by HCOs to report on patient experience, quality of care, and health outcomes. This also included a review of data routinely collected within electronic medical records (EMRs) and claims data. Our emphasis was on the identification of salient measures that can be quantified, compared between patient and client subgroups, and/or compared over time. We also sought to identify a range of examples for each health care setting, emphasizing well-constructed and validated measures with some or all of the following characteristics:

- assessed cultural competency
- captured language needs or preferences and/or were linked to other CLAS-related issues
- documented disparities
- were widely used and plausible for use in a range of HCOs (e.g., small or large)
 - were inclusive of measures that are used by several different quality reporting systems (e.g., sets of measures used by the Health Resources and Services Administration [HRSA], National Committee for Quality Assurance [NCQA], and Centers for Medicare & Medicaid Services [CMS])
- were previously endorsed in commissioned projects or reports for evaluating disparities
- were validated and/or psychometrically tested
- included cross-cutting measures across conditions and/or across settings.

The list of measures included in this report is not intended to be exhaustive, but to provide helpful examples of the types of measures HCOs might use to capture the implementation and impact of their specific changes. The toolkit accompanying this report, titled *Evaluation of the Implementation of the National CLAS Standards: Tips and Resources* (Williams et al., forthcoming), distills the elements of the evaluation framework and is intended to help guide the efforts of HCOs to evaluate the implementation of the National CLAS Standards within their own setting.

Organization of This Report

The remainder of this report provides additional information on the evaluation framework for the National CLAS Standards. Chapter Two presents the conceptual framework, while Chapters Three through Six present the individual logic models for each of the four settings prioritized in this study (ambulatory care, hospitals, behavioral health, and public health). The logic model summaries are stand-alone chapters for those readers who may be interested in a particular type

of setting. Because the logic model chapters are meant to stand alone, some text is repeated in these chapters. Chapter Seven summarizes the key evaluation questions for assessing the implementation of the National CLAS Standards within an organization and the process and impact measures that HCOs may wish to use to help answer these questions. Chapter Eight concludes with a summary of the evaluation framework and a brief overview of the companion toolkit to this report, which is designed to support health organizations in their efforts to implement the National CLAS Standards and improve their capacity to evaluate their approach.

Appendix A contains the list of the TAG members. Appendixes B through F contain detailed tables listing the cross-cutting process and impact measures and setting-specific measures for ambulatory care, hospitals, behavioral health, and public health.

Chapter Two. Conceptual Framework

As noted, in 2013, HHS OMH released the revised National CLAS Standards, establishing a new benchmark for culturally and linguistically appropriate services to improve the health of all individuals. These revised National CLAS Standards provided a vision of what culturally and linguistically competent care looks like when implemented to its fullest and offered practical suggestions for how this vision could be implemented within health care settings. HHS OMH asked RAND to help develop a long-term evaluation framework for the National CLAS Standards in a range of health settings, which include health care settings as well as broader settings responsible for the promotion of health and well-being. The conceptual framework shown in Figure 2.1 is a key element of this effort.

This conceptual framework is overarching in that it is relevant across a range of health settings, including ambulatory care centers (such as Federally Qualified Health Centers [FQHCs]), hospitals, behavioral health settings, and public health agencies. This conceptual framework was adapted from an existing model developed by Greenhalgh and colleagues (2004) that is focused on the diffusion of innovations in health service organizations. The framework conceptualizes the National CLAS Standards as an innovation to be adopted within the health setting. The ultimate goal to be achieved through the adoption of the National CLAS Standards is defined in the Principal Standard (Standard 1): “to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs” (HHS OMH, 2013).

Our conceptual framework describes the inputs, activities, outputs, and outcomes occurring within the health organization and illustrates how the National CLAS Standards are implemented and adopted. The framework also highlights the important roles of community and stakeholder engagement and partnerships for the diffusion and sustainability of the National CLAS Standards within an organization and explicitly acknowledges the broader environmental and policy context that can affect progress.

Whether and how readily an organization is willing and able to adopt the National CLAS Standards depends on a number of factors relevant to the National CLAS Standards themselves. This includes the organization’s understanding of them, the availability of guidelines and examples of best practices, and the perceived relative advantage to the organization of implementing the National CLAS Standards. Organizations will need to assess how compatible the National CLAS Standards are with current organizational goals, practices, and other regulations or guidelines they must follow and how complex or easy the National CLAS Standards are to understand and adopt into practice.

National CLAS Standards
 Framework and guide for health care providers and policymakers to ensure that quality of care and needs of diverse populations are met. The overarching goal, or the *Principal Standard*, is: To provide effective, equitable, understandable, respectful, and quality care and services (Standard 1).

The overall standard has three themes:

- *Governance, leadership, and workforce* (Standards 2–4)
- *Communication and language assistance* (Standards 5–8)
- *Engagement, continuous improvement, and accountability* (Standards 9–15)

Engagement and Partnerships
 Linkages between the health organization, the community, and other stakeholders are present at all stages of National CLAS Standards adoption. They provide relevant inputs and information to help assess need and guide the process; participate in the design, adoption, and implementation of activities; and support communication about changes; and are impacted by outputs and outcomes. Linkages evolve over time to include new partners and tasks.

Environmental/Policy Context
 Activities depicted in this model occur within a broader environmental and policy context. This includes, for example, the regulatory environment, mandates, and standards of practice. The dashed lines around the organization indicate that this context is likely to influence an organization's readiness for change; whether, when, and how National CLAS Standards are adopted; and the ease with which changes within the organization can be made to meet National CLAS Standards.

Health Organization

The diagram illustrates the flow of information and processes within a health organization, influenced by the National CLAS Standards and the Environmental/Policy Context. The organization is shown as a central entity with three main components: *Antecedents and Inputs*, *Readiness for National CLAS Standards*, and *Development of Implementation Strategies and Communication*. These components are linked by a vertical flow, with *Antecedents and Inputs* leading to *Readiness for National CLAS Standards*, which leads to *Development of Implementation Strategies and Communication*, which leads to *Adoption/Implementation*, which leads to *Outputs and Outcomes*. A feedback loop labeled *Quality Improvement* connects *Outputs and Outcomes* back to *Antecedents and Inputs*. The organization is also linked to the *Environmental/Policy Context* via a *LINKAGE* arrow. The *Environmental/Policy Context* is represented by a dashed box containing *HHS OMH*, *Community*, and *Other Stakeholders*. The *Health Organization* is represented by a solid box containing the three main components. The *Antecedents and Inputs* component is highlighted in red, *Readiness for National CLAS Standards* in purple, and *Development of Implementation Strategies and Communication* in blue.

The section of the framework that is shaded in blue on the right-hand side describes the diffusion of the National CLAS Standards within a given health organization. It includes organization-specific antecedents and inputs; readiness for adopting the National CLAS Standards; the development of implementation strategies and communication about proposed strategies; activities related to the adoption, assimilation, and diffusion of the National CLAS Standards; and outputs and outcomes to both internal and external audiences.

Antecedents and inputs relevant to the implementation of the National CLAS Standards include the organization's strategic goals, policies, dedicated staff and resources, physical environment, and external resources. Also relevant is the organization's capacity to absorb new knowledge and receptivity for change, which may be driven, for example, by a gap analysis or needs assessment. Examples of antecedents and inputs are described below.

- 8

competency issues—such as recruitment and retention of a diverse workforce, language services, and training and development—will strengthen the implementation of activities related to the National CLAS Standards (Lewin Group, 2002; Wilson-Stronks and Galvez, 2007). These internal policies should at least conform with external regulatory and statutory policies.

- **Dedicated staff and resources** confirm an organization's commitment to cultural competency by dedicating resources and designating staff for cultural competency activities. Evidence of dedicated resources can be found in budgeted resources for cultural competency activities (Lewin Group, 2002; Wilson-Stronks and Galvez, 2007). Dedicated staff can include an executive-level staff member and a department or office that focuses on multicultural and/or linguistic issues. Dedicated staff can be instrumental in coordinating organization-wide initiatives and monitoring progress toward cultural competency goals (Brach, Paez, and Fraser, 2006; Wilson-Stronks and Galvez, 2007).
- **The physical environment** includes culturally sensitive design and architecture and physical environments in which the décor, artwork, posters, and literature reflect the diversity of the service area (Lewin Group, 2002). It also includes appropriate signage in the major languages spoken in the service area (HHS OMH, 2001).
- **External resources**, such as partnerships with the community or other stakeholders, can be valuable inputs to the process through shared meaning and mission, knowledge, and other resources (e.g., personnel, materials).
- An organization's **capacity for new knowledge**—building on an organization's preexisting knowledge and skills base relative to the National CLAS Standards—is the ability to find, interpret, and use new knowledge and share that knowledge through internal and external networks. This is related to the completion of a gap analysis or needs assessment that may help to inform activities that may be undertaken to meet the National CLAS Standards.
- An organization's **receptivity for change** includes the type of leadership and vision within the organization, the risk-taking climate, and whether the organization has clear goals and priorities that align with the National CLAS Standards.

Readiness for the National CLAS Standards

Regardless of whether antecedents and inputs relevant to successful implementation of the National CLAS Standards are present, they likely will not be implemented if the health setting or organization is not ready to change. Readiness for change may be affected by a number of factors, including the following:

- **A recognition of the need for change:** The organization recognizes a clear need for change relative to its ability to provide effective, equitable, understandable, and respectful quality care and services that are responsive to a diverse population.
- **Business case and quality improvement case:** One of the major organizational barriers for the National CLAS Standards is the perceived impact it may have on costs. It is therefore important that both the business case and the quality improvement case for the National CLAS Standards have been made (e.g., leadership and staff see how implementation can improve outcomes and the financial bottom line).

- **Leadership and executive buy-in:** Activities related to the National CLAS Standards are most effective when the organization’s governing board and top management embrace cultural competence and communicate this support throughout the organization (Brach, Paez, and Fraser, 2006; Dansky et al., 2003). This includes incorporating criteria related to the National CLAS Standards into the performance evaluation and reward systems.
- **Champions or change agents,** either individually or as a group, who can spearhead forward momentum and help address readiness for adopting the National CLAS Standards throughout the broader organization.

Development of Implementation Strategies and Communication

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must plan and design relevant activities and approaches to close these gaps and develop thoughtful implementation strategies for the proposed changes. Organizations may adopt the National CLAS Standards all at once or in a staged approach, depending on the antecedents and inputs, readiness, and the environmental and policy context. Many of the National CLAS Standards themselves can be viewed as thoughtful implementation strategies for the provision of effective, equitable, understandable, and respectful quality care and services. A review of 73 implementation strategies identified in the Expert Recommendations for Implementing Change (ERIC) study (Powell, Waltz, et al., 2015), for example, identified nine categories of strategies: (1) engage consumers, (2) use evaluative and iterative strategies, (3) change infrastructure, (4) adapt and tailor the context, (5) develop stakeholder interrelationship, (6) utilize financial strategies, (7) support clinicians, (8) provide interactive assistance, and (9) train and educate stakeholders. Many of these strategies are reflected or implicit in the National CLAS Standards, with examples provided below.

- **Appoint a committee of stakeholders to guide activities related to the National CLAS Standards.** This committee should include organization staff, members of the community, and other stakeholders who can bring unique perspectives to the planning process.
- **Design and plan changes or activities to address identified needs.** Such changes may relate to one or more of the National CLAS Standards:
 - *Governance, leadership, and workforce (National CLAS Standards 2–4).* One example of an activity meeting these National CLAS Standards is the development of cross-cultural communication skills among all staff, including skills to obtain culturally relevant data, such as those used in conducting cultural assessments and culturally based physical assessments (Campinha-Bacote, 2002; Kim-Godwin, Clarke, and Barton, 2001; DeRosa and Kochurka, 2006; Hobgood et al., 2006). This also includes skills needed in “identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism” (Betancourt et al., 2003).
 - *Communication and language assistance (National CLAS Standards 5–8).* The National CLAS Standards related to patient communication can be pivotal in

- improving the patient experience. This includes, for example, providing interpreter and translation services. High-quality interpreter services are needed at all points of patient contact to improve provider and staff communication with patients with limited English proficiency (LEP). Accurate communication increases the likelihood of receiving appropriate care (HHS OMH, 2001; Anderson et al., 2003; Wilson-Stronks and Galvez, 2007).
- *Engagement, continuous improvement, and accountability (National CLAS Standards 9–15).* Activities within this set of National CLAS Standards may foster refinement between adoption, implementation, and outcomes. One example of an activity meeting these specific National CLAS Standards may be implementing mechanisms for collecting data on cultural subgroups, such as race/ethnicity, language preferences, education, and income, and integrating these data into the information systems (HHS OMH, 2001; Lewin Group, 2002). These data are important for strategic and service planning and can be used to monitor health care disparities and for quality improvement (QI) (Betancourt, Green, and Carrillo, 2002).
 - **Develop implementation strategies.** This stage should include the development of implementation strategies for the proposed changes. Implementation strategies are defined as “methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice” (Powell et al., 2015).
 - **Communicate about the National CLAS Standards’ implementation and activities.** Communication should occur internally to promote acceptance and understanding of upcoming changes. It is also important to communicate about the implementation, activities, and expectations of the National CLAS Standards to contracted or network providers and partners because they will influence the organization’s overall CLAS performance with respect to the National CLAS Standards. External communication may also improve community relations if organizations can raise public awareness of the activities and their progress in meeting goals related to the National CLAS Standards (HHS OMH, 2001; Lewin Group, 2002). External communication can include a statistical annual report on patient demographics, interpreter use and availability, translated materials, staff training in cultural competency, and survey results of patient experiences with care. This can serve as a marketing tool while enhancing the organization’s image among diverse communities.

Adoption/Implementation

Once activities to address gaps in the National CLAS Standards have been identified and designed, they must be adopted, implemented, and devolved to frontline teams for execution. Successful implementation may require

- a hands-on approach by leadership and managers to ensure fidelity to the implementation plan and feedback on progress
- human resources involvement, especially related to training, professional development, and workforce evaluations
- collection, monitoring, and use of data on race, ethnicity, sex, sexual orientation, disability status, and language

- tracking of process and outcome data to assess progress in achieving goals—along with data on the population served, these data should inform continuous quality improvement (CQI) efforts
- dedicated resources and time to allow for full implementation of planned changes.

Outputs and Outcomes

The activities and changes implemented within the organization are expected to result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include

- incorporating diverse viewpoints from inside and outside the organization into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the organization's mission, goals, and policies and making them central to the organization's functions
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse providers and staff at all levels of the organization
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain National CLAS Standards-related initiatives and efforts are available
- ensuring that staff understand the benefit of implementing the National CLAS Standards for both the organization and the individuals they serve.

Collectively and over time, such outputs may contribute to changes in outcomes for both the organization as a whole and for the individuals engaging in services. It is expected that some outcomes will take longer to realize. Examples of outcomes are provided below.

- Outcomes for the organization:
 - the provision of quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
 - data that are used to monitor and improve service delivery with respect to the National CLAS Standards
 - improved two-way communication and feedback mechanisms between individuals and health care settings
 - organizational culture shifts to provide ongoing and visible support for the National CLAS Standards
 - continued improvement in the provision of high-quality services related to the National CLAS Standards
 - increased trust and engagement between the community and the health care setting.

- Outcomes for the individuals seeking care:
 - access to high-quality language services
 - increased ability to access and navigate care
 - increased ability to understand care and make informed care decisions
 - greater adherence to care plans, completing treatment, and appropriate follow-up
 - being empowered to become active participants in their health
 - improved satisfaction
 - better health outcomes
 - increased trust between individuals and providers.

Quality Improvement

Organizations should integrate the National CLAS Standards into their QI activities, as depicted in the model. QI can be viewed as an organization-wide approach to planning and implementation of continuous improvement in performance. As such, QI “emphasizes continuous examination and improvement of work processes by teams of organizational members trained in basic statistical techniques and problem-solving tools and empowered to make decisions based on the analysis of data” (Weiner et al., 2006). For example, HCOs can use QI activities to address health disparities in access, outcomes, or patient experiences with care.

The outputs and outcomes generated as a result of the implementation of the National CLAS Standards also feed back to the broader community and other stakeholders. For example, if anticipated impacts of the National CLAS Standards are realized, the needs of the community over time may change, relationships between the health system and community may strengthen, and new opportunities for partnership may arise. Furthermore, as the number of organizations meeting the National CLAS Standards increases within a given community or system, the collective impact may affect outcomes at the community, system, and/or policy levels, although this will take a longer period of time. At the system level, this may include improved quality of care, increased capacity of the health system to address the needs of diverse populations, increased equity, reduced disparities, and lower health care costs. It may also result in improved population health overall.

Linkages with the Community and Other Stakeholders

Successful implementation of the National CLAS Standards requires clear and meaningful linkages between the health setting, the community, and relevant stakeholder groups to understand and address the cultural and linguistic needs of the communities served (Weech-Maldonado and Merrill, 2000; Wilson-Stronks and Galvez, 2007). Such stakeholders may include tribal or community-based organizations, such as human, social service, and religious organizations, as well as liaisons like community health workers (Lewin Group, 2002; Brach and Fraser, 2000). Linkages between the organization and community should occur throughout the process. For example, in the design stage, such linkages may promote a shared mission, effective

knowledge transfer, and lessons learned from past efforts. Community members and representatives from various stakeholder groups should also participate in any gap analysis or needs assessment (see the “Antecedents and Inputs” section earlier in this chapter) and workgroups to develop solutions to address gaps (see the “Adoption/Implementation” section earlier in this chapter). Linkages with the community and with other stakeholders are also critical for implementing planned changes or activities, particularly with respect to information- and data-sharing, implementation support, and resource-sharing (e.g., joint training). Finally, linkages with the community and other stakeholders are important for communicating with key audiences about the National CLAS Standards and about improvements made within the organization. It is important to note that both formal and informal linkages also occur between the community, other stakeholders, and HHS OMH.

Linkages with HHS OMH also exist within the health setting, through the development of the National CLAS Standards, through the sharing of best practices and lessons learned, and through the development of the evidence base to assess the effectiveness of the National CLAS Standards. This linkage, however, is not as strong or as often utilized as linkages with the community.

Environmental and Policy Context

Implementation of the National CLAS Standards within an organization is affected by a number of factors external to the organization itself, including

- the federal, state, and local regulatory environment (e.g., ACA, Civil Rights Act, Public Health Service Act)
- accreditation mandates
- policies
- incentives and payment models (e.g., for culturally competent care)
- standards of practice
- reporting requirements (e.g., CAHPS).

In many cases, these factors influence how care is delivered and monitored and may impact whether and how organizations choose to adopt the National CLAS Standards. To the extent that the National CLAS Standards align with many of these existing regulatory and reporting requirements, organizations may be more likely to adopt the National CLAS Standards. However, if organizations see the National CLAS Standards as duplicative or as additional work for their already overtaxed organization, they may be less likely to adopt the National CLAS Standards. In the framework in Figure 2.1, the environmental and policy context surrounds the health organization and the entire process of adopting the National CLAS Standards, but the dashed lines around the organization are meant to indicate that the environmental and policy context is both a foundation for these activities and an important driver for them within an organization.

Conclusion

This framework conceptualizes the National CLAS Standards as an innovation to be adopted within health care settings. It was designed to be relevant across a range of health and health care settings, including ambulatory care centers (such as FQHCs), hospitals, behavioral health settings, and public health agencies. Building from the conceptual framework, the next step was to formalize specific logic models for the four different types of health and health care organizations addressed in this effort. By clearly defining the inputs, activities, outputs, and short- and long-term outcomes resulting from the awareness, adoption, and implementation of the National CLAS Standards within the HCO, the logic models provide a solid foundation for the design of an evaluation and help to ensure that the measures used capture relevant processes and potential impacts. The setting-specific logic models are described in the following four chapters on ambulatory care (Chapter Three), hospitals (Chapter Four), behavioral health (Chapter Five), and public health (Chapter Six).

Chapter Three. Ambulatory Care Logic Model

Ambulatory (i.e., walk-in) or outpatient care settings are where the vast majority of health care is received in the United States. It is estimated that there are more than 928 million outpatient visits to physician offices each year and more than 125 million outpatient visits to hospitals (Centers for Disease Control and Prevention [CDC], 2016b). Ambulatory care settings (ACSs) include doctors' offices, outpatient clinics, community clinics, Federally Qualified Health Centers (FQHCs), rehabilitation centers, urgent care, emergency rooms, and ambulatory surgery clinics, as well as other settings. Depending on the type of ACS, they can range in size from a few clinician providers and support staff serving several hundred patients to several hundred providers and support staff serving tens of thousands of patients. ACSs can be freestanding or part of a larger medical facility, such as a medical center. Each ACS may operate independently with its own management (e.g., an FQHC), as part of a larger organization (e.g., a primary care division within a hospital or a large multispecialty group), or as one of a network of organizations (e.g., a large physician provider group made up of private practices throughout a community but with shared management services and oversight).

Despite these differences, health care providers and organizational leaders within and across all types of ACSs share challenges and responsibilities with respect to recognizing and ensuring that cultural and linguistic issues are adequately addressed. While cultural and linguistic needs and concerns are often thought of as mainly relevant to community clinics or FQHCs that serve predominantly minority and/or low-income populations, the reality is that, with growing numbers of insured individuals and demographic changes in the United States, these issues are becoming increasingly relevant in almost all types of ACSs.

In this report, our focus is on ACSs that are sufficient in size and resources to have one or more management staff focused on quality improvement (QI) and/or cultural or language activities, as in the case of the other types of health care organizations (HCOs) discussed. Awareness of cultural and linguistic needs and guidelines is also salient to providers and staff in smaller ACSs (e.g., cultural competence training is still essential for clinicians and staff), but formally implementing all of the National CLAS Standards may not be feasible in these settings. Examples of ACSs where the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH)'s National CLAS Standards are directly applicable include FQHCs, urgent care centers or outpatient divisions in medical centers, large physician groups (e.g., independent physician associations, independent practice associations), and multispecialty clinics. The National CLAS Standards are also applicable to managed health plans and a variety of different types of emerging managed care organizations, such as accountable care organizations (ACOs).

While leadership and staff in some types of ACSs may have extensive experience and well-established infrastructure to provide culturally and linguistically appropriate services (e.g., FQHCs or some health plans), such resources may be more variable and less developed throughout the HCOs in other types of ACSs. Consequently, in many ACSs, the risk of cultural misunderstandings or language barriers remains high for growing subgroups of patients (Institute of Medicine, 2004). While failure to provide culturally and linguistically appropriate services is likely to result in lower satisfaction for the patient and provider, in many cases and settings, this can have more-dire effects. For example, routine miscommunications and cultural misunderstandings in a private multispecialty clinic between providers and patients with significant cardiac risk factors could potentially reduce the likelihood that patients will properly use or adhere to prescribed medications and thus could increase largely preventable heart attacks or strokes in the patients served.

An additional layer of complexity in the United States with respect to understanding and addressing the needs of diverse populations served in ambulatory settings relates to the role of managed care plans operated by large health insurers and health reforms intended to promote more value and better outcomes for health care beneficiaries. Managed care plans receive funds from payers (employers, government, and individuals) to help ensure that enrolled members receive quality care at reasonable costs. The managed care plans, in turn, contract with providers and HCOs and pay them a portion of the funds to deliver the actual health care. Increasingly, the focus of payers and, consequently, health insurers, is on value-based payments. Value-based payment systems are intended to reward health care providers and delivery systems that can show higher quality scores on the measures of care delivered to their patients and on the health outcomes experienced by those patients. (To receive full payments or bonuses, contracted providers and the delivery system also generally need to keep average costs of the care for patients they serve at a relatively low level.)

The growing emphasis on value-based care is increasing the salience of addressing diverse cultural and linguistic needs for ACSs. For example, the fact that payments to providers in ACSs increasingly depend on the outcomes of their patient population is compelling ACS leaders to better understand the populations they serve and address disparities between patient subgroups when found. Providing further motivation for ACS leaders to begin routinely examining whether patterns of care and outcomes significantly differ for patients from racial/ethnic minority groups or patients who do not speak English, state and possibly federal entities are requiring health insurers (who pay providers) to begin tracking and acting on identified racial/ethnic or linguistic disparities in care and to implement other recommended National CLAS Standards and practices.

Logic Model for Implementing the National CLAS Standards Within the Ambulatory Care Setting

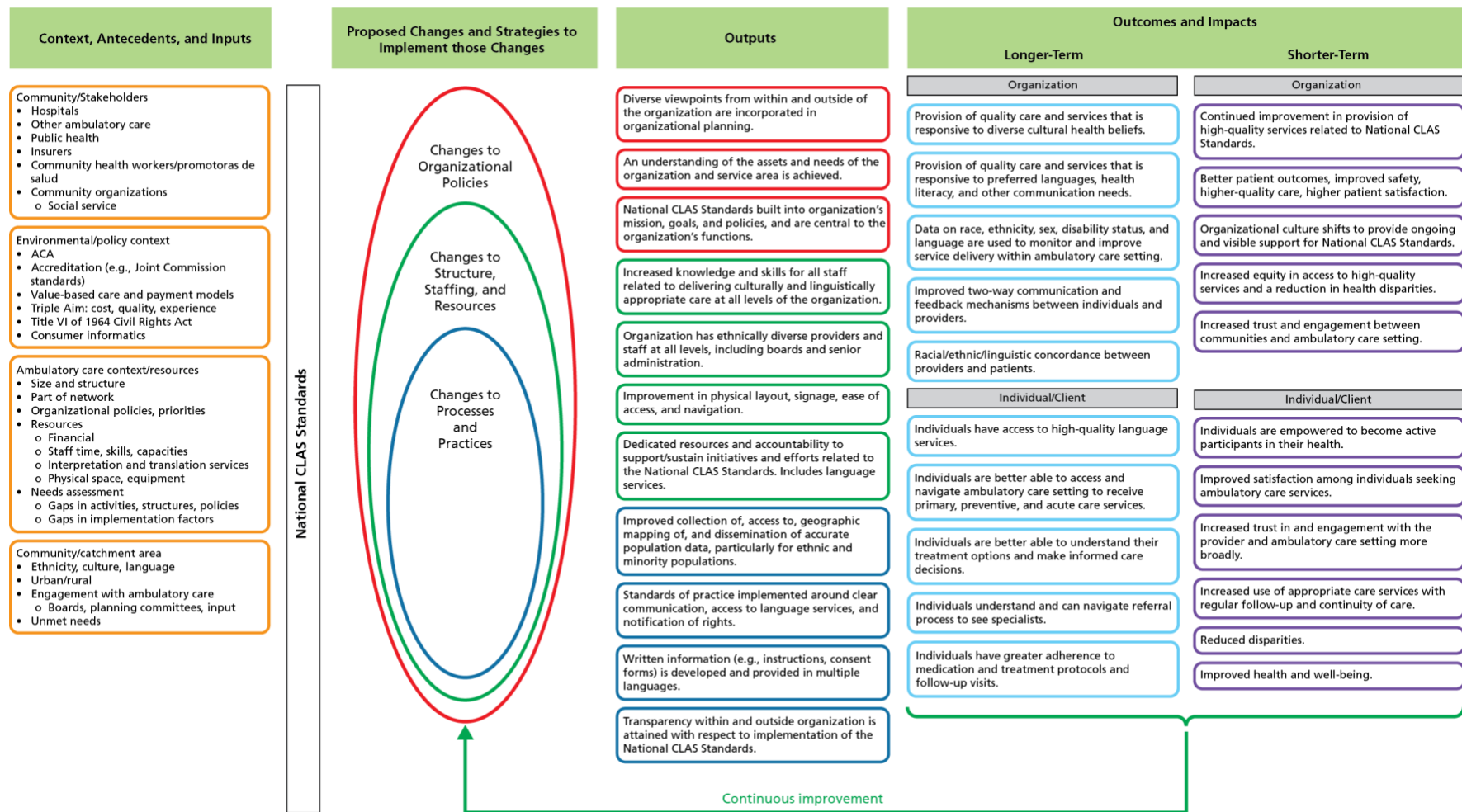
Figure 3.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within an ACS. Given the importance of the broader context, external resources, and partnerships in shaping an ACS's readiness for adopting the National CLAS Standards, we include them in the context, antecedents, and inputs section and note that any changes should be made in partnership with the community and other stakeholders.

Context, Antecedents, and Inputs

Linkages with the Community and Other Stakeholders

Of all ACSs, FQHCs tend to have more ties to local community partners, such as food pantries, shelters, churches, and hospitals, than other provider groups that tend to care for more private or commercially insured or Medicare patients. As a result, linkages with stakeholders and the broader community vary significantly, depending on the population served and the broader needs of the patient population. However, in a growing number of regions, large clinics and provider groups are beginning to work together through multistakeholder collaboratives and initiatives to improve care and outcomes of certain conditions. For example, as part of a project sponsored by the CDC, selected provider groups in Southeast San Diego are beginning to work in concert with local faith-based organizations to help reduce cardiac risks among people living in that region (Be There San Diego, undated). In early 2016, the Centers for Medicare & Medicaid Services (CMS) introduced the Accountable Health Communities Model (AHCM) to tackle the high prevalence of unmet health-related social needs that contribute to poor health and to address the current gap between clinical care and community services (CMS, 2016a). In the AHCM, universal, comprehensive screening in the areas of housing instability and housing quality, food insecurity, utility needs, interpersonal violence, and transportation needs will be conducted in the ACSs, and affected individuals will be linked to social services (CMS, 2016a; Alley et al., 2016). Questions about whether and how these models most effectively address health inequities and reduce health disparities will be answered over time, but all point to a need to consider how ambulatory care centers work with their partner and contracted organizations with respect to the National CLAS Standards because this may influence their overall performance. Such partners should be involved at all steps of the process (e.g., assessment, design, implementation, evaluation).

Figure 3.1. Logic Model for Implementation of the National CLAS Standards Within the Ambulatory Care Setting



Environmental and Policy Context

Implementation of the National CLAS Standards within an organization is affected by a number of factors external to the organization itself. These factors include, for example, the federal, state, tribal, and local regulatory environment; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may impact whether and how organizations choose to adopt the National CLAS Standards.

Health care, especially in ACSs, has been undergoing unprecedented changes during the past decade, and it is likely that some aspects of care in some ACSs will be unrecognizable five years from now. These changes are being driven partly by health care reforms, such as the Affordable Care Act (ACA), as well as by the convergence of other factors, such as breakthroughs in mobile and wireless communications and biomedical advances. While these sorts of changes are manifesting in different ways, some of the most notable shifts relevant to the implementation of the National CLAS Standards include the following:

- **Increasing emphasis on value-based care.** Requirements have been increasing for reporting ambulatory care quality measures, including process and intermediate outcomes measures—e.g., Health Indicators Warehouse’s Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality’s (AHRQ’s) Ambulatory Consumer Assessment of Healthcare Providers and Systems (Bureau of Primary Health Care, 2015). This increase is partly driven by newer financing and care delivery models, which tie payments or other incentives to positive clinical outcomes among the ACS’s patient population. Because outcomes tend to be worse in minority and/or lower-socioeconomic-status populations where cultural and linguistic needs are thought to play a prominent role, ACS leaders may be motivated to adopt and apply the National CLAS Standards. However, widespread uptake and full implementation of the National CLAS Standards will likely take time in many ambulatory settings, particularly in smaller sites, because of competing demands, bandwidth issues, and a focus primarily on improving quality scores for the overall population.
- **Improving health care and consumer informatics.** Many, though not all, ACSs have undergone a transformation in recent years with respect to improvements in their electronic medical records and in their access to easy-to-use data analytics tools to support QI efforts. At the same time, consumers’ access to interactive web tools with provider or regional-level quality report cards has been proliferating (CMS, 2016b). While the norm has been to show only quality scores for the overall patient populations that ambulatory providers serve, expectations for reporting quality scores for major racial/ethnic and linguistic groups (when there are enough patients to ensure confidentiality) will likely increase as race/ethnicity and language data become more readily available in non-FQHC ambulatory sites.
- **Leveraging meaningful use of health information technology (HIT) to reduce health disparities.** The Health Information Technology for Economic and Clinical Health (HITECH) Act was intended to promote the adoption and meaningful use of HIT (HHS, undated). One of the Act’s stated goals is to address health disparities. The Electronic

Health Record Incentive Program, commonly referred to as “Meaningful Use,” provides a relatively untapped opportunity to help ACSs collect more-granular data on patients’ race, ethnicity, language, and other relevant characteristics. Given the increasing use of patient portals and other HIT that enables patients to access health information, decision support tools, test results, and correspondence with providers, some are calling for an expansion of Meaningful Use criteria to ensure that such technologies are being developed and implemented with the National CLAS Standards in mind (Consumer Partnership for eHealth, 2013).

- **Health care reforms and demographic shifts.** As alluded to previously, not only is the overall U.S. population quickly becoming more ethnically, culturally, and linguistically diverse in most geographic regions, but Medicaid expansion and the establishment of commercial insurance health plan exchanges in many states are further changing the typical mix and flow of patients to different types of ACSs.

Finally, there are a number of other influences relevant to the provision of culturally and linguistically appropriate services more broadly. For example, under Title VI of the Civil Rights Act of 1964 (Chen, Youdelman, and Brooks, 2007), organizations receiving federal funds must take reasonable steps to provide meaningful access to their programs for individuals with limited English proficiency (U.S. Department of Justice, 2000). Furthermore, several states have recognized the importance of cultural and linguistic competency by legislating competency training in health care (HHS OMH, 2013). Accrediting bodies—such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—have also established accreditation standards that target the improvement of communication, cultural competency, and patient-centered care and the provision of language assistance services (Briefer French et al., 2008; Wilson-Stronks and Galvez, 2007; HHS OMH, 2013).

The above examples of external influences and contexts may impact whether and how an ACS will adopt the National CLAS Standards and how easy or difficult such implementation may be.

Ambulatory Care Context, Resources, Community, and Catchment Area

Inputs and antecedents relevant to implementing the National CLAS Standards can vary considerably depending on the type of ACS (e.g., FQHC, small office, large practice) and on whether the ambulatory care location is part of a larger network. Practice size and group organization play an increasingly important role in many ACSs and can be a major factor in the uptake and implementation of the National CLAS Standards. For example, while smaller clinics or provider groups are much less likely to have the capacity or bandwidth to address diverse cultural and linguistic needs, larger clinics and provider groups may have staff members specifically tasked with leading or managing aspects of implementing and assessing the National CLAS Standards within the clinic or network providers. However, one advantage of smaller clinics is that they may be nimbler and can come to know and respond to their patient population’s needs better than some of the bigger, higher-volume clinics. Other inputs and antecedents—such as the ACS’s strategic goals, policies, staff, resources, and physical space—

may also play a role in the center's ability to adopt and implement the National CLAS Standards. For example, a lack of sufficient space and staff is often cited as a barrier to other types of QI efforts and may affect an organization's ability to implement the National CLAS Standards.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven, for example, by a gap analysis or a needs assessment. This assessment should include activities, structures, or policies that should be in place to support equitable care as well as implementation factors that could aid or hinder the adoption of the National CLAS Standards. The use of gap analyses varies in ACSs, but it generally falls under the rubric of continuous quality improvement and may be completed as part of ongoing accreditation requirements.

National CLAS Standards

In this logic model, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Here, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted and which help to shape the activities the organization chooses to implement to address gaps in culturally and linguistically appropriate care.

Proposed Changes and Strategies Developed to Implement Those Changes

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must design relevant activities and approaches to close the gaps and develop implementation strategies to enhance the adoption and sustainability of those changes (Powell et al., 2015). Organizations may adopt the National CLAS Standards altogether or in a staged approach, depending on the antecedents and inputs, the organization's readiness for implementing the National CLAS Standards, and the environmental and policy context. Given the wide range of potential approaches and activities an ACS may choose to develop or adopt, the logic model does not list specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices.

Changes to organizational policies include making the National CLAS Standards central to the organization's functions and building them into the organization's mission, goals, and policies. Engaging diverse viewpoints both from inside and outside the ACS into planning is particularly important. Building this orientation to the National CLAS Standards into the organization's approach is especially important when the ACS seeks to implement the National CLAS Standards across multiple providers and office locations.

Changes to an ACS's organizational structure, staffing, and resources require that the ACS leaders have identified the necessary skill set for their staff to address the diverse cultural and linguistic needs of their patient population and require that they have the capacity to train staff when necessary. The organization should be focused both on diversifying its frontline staff and

on having an ethnically diverse staff at all levels, including boards and senior administration. Changes to organizational structure include making improvements in the ease of access to its physical space and to the accessibility of information it provides to consumers through signage. In addition, the ACS should have dedicated resources to support and sustain the implementation of the National CLAS Standards, including the availability of language services and a process for holding itself accountable for these improvements.

Changes to processes and practices encompass all of the unique functions of ambulatory care, including the provision of health care and services, diagnostic testing, treatment and follow-up, and referral to specialty providers. Changes would also involve a number of other relevant tasks, including health education, obtaining consent, discussing the use or sharing of medical data, and health insurance and billing.

The design and development of activities to address those gaps and the development of an implementation strategy will benefit from close collaboration with, and input from, the community and other stakeholders that stand to benefit from such changes. Because of the heterogeneity of ACSs, the results of these gap analyses will be very different. Many ACSs, such as FQHCs, are uniquely positioned to draw out these lessons from stakeholders because of their long-standing partnerships, but not all ACSs are. Building a focus on the National CLAS Standards into organizational policy, practice, staffing, and resources is critical to ensuring that every ACS, no matter the context, takes appropriate steps to ensure that its services are accessible to all members of the community.

Outputs

The activities and changes implemented within the organization should result in immediate outputs that move the organization toward providing culturally and linguistically appropriate care and services. Such outputs may include

- incorporating diverse viewpoints from inside and outside the ACS into planning and implementation of policies, programs, and services and building the National CLAS Standards into the ACS's mission, goals, and policies
- implementing standards of practice around clear communication, access to language services, and notification of rights.
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse public health practitioners and staff at all levels of the organization
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain initiatives and efforts related to meeting the National CLAS Standards are available.

The above serve as examples of potential outputs. The specific outputs expected will be determined by which National CLAS Standards have been adopted, which organizational changes have been made, and which activities have been implemented as a result.

Outcomes

Collectively and over time, outputs from the ACS may contribute to changes in outcomes for individuals using ambulatory care services, as well as for the ACS organization overall. Examples of potential outcomes are listed below.

- Outcomes for the organization
 - Short term (1–2 years)
 - the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
 - use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve service delivery within the ACS
 - improved two-way communication and feedback mechanisms between individuals and providers
 - enhanced or improved racial/ethnic and linguistic concordance among providers, ambulatory care staff, and patients
 - Longer term (3 or more years)
 - continued improvement in the provision of high-quality services related to the National CLAS Standards
 - better patient outcomes, improved safety, higher-quality care, and higher patient satisfaction
 - organizational culture shifts to provide ongoing and visible support for the National CLAS Standards within the ACS
 - increased equity in access to high-quality services and a reduction in health disparities
 - increased trust and engagement between communities and ACSs.
- Outcomes for the individuals seeking care
 - Short term (1–2 years)
 - access to high-quality language services
 - increased ability to access and navigate ambulatory care services to receive primary, preventive, and acute care services
 - increased ability to understand treatment options and make informed care decisions
 - ability to understand and navigate the referral process to see specialists
 - greater adherence to medication and treatment protocols and follow-up visits
 - Longer term (3 or more years)
 - empowerment to become active participants in their health
 - improved satisfaction among those seeking ambulatory care services

- increased trust in and engagement with the provider and ACS more broadly
- increased use of appropriate care services with regular follow-up and continuity of care
- reduction in disparities
- improved health and well-being.

Quality Improvement

The logic model depicts adoption and implementation of the National CLAS Standards as a continual process, requiring a QI loop in which outputs and outcomes inform the development of future ACS actions, policies, or programs to better align with the National CLAS Standards. Standard QI efforts, however, are broadly targeted to the general patient population and may maintain or increase health disparities (Green et al., 2010). Culturally competent QI tailors care to address the specific language and culture barriers, which both helps to reduce disparities and can improve care for everyone (Green et al., 2010). It is important that QI improvements be viewed specifically through a culturally competent lens when assessing the impact of the implementation of the National CLAS Standards and informing next steps.

Chapter Four. Hospital Logic Model

There are more than 5,500 registered hospitals in the United States, the majority of which are community hospitals. These consist of not-for-profit, for-profit, or state and local government community hospitals (American Hospital Association [AHA], 2016). Other hospital types include federal government hospitals, psychiatric hospitals, and long-term care hospitals. In 2011, hospitals collectively conducted more than 125.7 million outpatient visits (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics [NCHS], 2016) and were responsible for about 35 million hospital discharges from inpatient care (CDC NCHS, 2016). While hospitals have traditionally focused on meeting the clinical needs of their patients through patient safety and high-quality care (The Joint Commission, 2010), such patient characteristics as language, culture, and other nonclinical needs can affect how individuals approach and participate in health care while in the hospital and during critical periods of transition, such as discharge.

Hospitals across the United States are increasingly serving diverse patient populations; some may have limited English proficiency (LEP) or no English proficiency. Findings from a national survey of hospitals revealed that 63 percent of hospitals reported encountering patients with LEP on a daily or weekly basis (Hasnain-Wynia et al., 2006). A 2009 survey of hospitals indicated that while 92 percent provided language services, about one-quarter used only one modality for providing such services. The most commonly used services are either over-the-phone interpreting services or the use of hospitals' own bilingual staff as interpreters. Often, these bilingual staff have not been assessed for their linguistic proficiency nor trained on interpreting skills. In addition to the limitations in interpreting services, only 55 percent of respondents indicated that their hospital provided translation services of written documents (Cyracom, 2010). Similarly, a national survey by the AHA and the Institute for Diversity in Health Management (IFD) indicated that hospitals' attention to diversity management and cultural competence practices is somewhat limited. While 77 percent of responding hospitals collected patient demographic data, only 18 percent used these data to benchmark gaps in care. Fewer than half provided comprehensive cultural competence training (AHA and IFD, 2012). Providing culturally and linguistically competent care is crucial to ensuring a satisfactory patient experience, effective communication between patients and providers, and positive treatment outcomes (Gertner et al., 2010). If culturally and linguistically appropriate services are not provided in hospitals, patients may not be able to communicate effectively with their providers or adhere to care plans, hospitals will continue to put themselves and their patients at risk for negative consequences, and racial and ethnic disparities in health care may continue to increase (Wilson-Stronks and Galvez, 2007; The Joint Commission, 2010). Furthermore, given the increased emphasis on value-based care in the U.S. reimbursement system and paying for

quality, hospitals that are not responsive to the cultural and linguistic needs of the patient population may see a negative impact on their financial performance.

One example of how providing culturally and linguistically appropriate care can improve quality while financially benefiting the hospital relates to readmissions. Hospitals are now being penalized for excess readmissions for several acute conditions, such as acute myocardial infarction (AMI), health failure, and pneumonia. Betancourt, Tan-McGrory, and Kenst (2015) outlined several issues related to cultural and linguistic competence that may play a key role in driving higher readmission rates among diverse patient populations. For instance, having LEP is associated with lower rates of follow-up, decreased use of preventive services, lower rates of adherence to medications, and lower comprehension of discharge instructions and diagnosis, which may be tied to readmissions (Rodriguez et al., 2011; Karliner et al., 2012). Health literacy-related issues—including limited knowledge of conditions, poor medication management and self-care, and lack of adherence to treatment plans—may also influence readmission rates among minorities (Berkman et al., 2011; Evangelista et al., 2010; Mitchell et al., 2012). Additionally, cultural factors may contribute to readmissions. In particular, cultural beliefs and customs can impact patients' health behaviors, care perceptions, and understanding of medical information or advice (Li et al., 2006; Davidson et al., 2007; Dickson et al., 2013). Implementing culturally and linguistically competent care and activities may effectively address the aforementioned issues, thus lowering hospital readmission rates and costs.

Brach and Fraser (2002) have presented the business case for cultural competency and have identified four interrelated financial incentives for cultural competency in hospitals.

- Cultural competency increases the hospital's appeal to diverse populations and, thus, increases its market share. This is particularly critical as the U.S. population becomes increasingly diverse.
- Cultural competency can improve the performance of hospitals in publicly reported quality and patient experience measures. This is important given that value-based purchasing reimbursement is increasingly tied to these metrics. A study by Weech-Maldonado et al. (2012c) shows a positive relationship between adherence to the National CLAS Standards and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores among hospitals.
- Public purchasers, such as Medicaid and Medicare, increasingly are instituting cultural competency requirements in their contracts. Hospitals must comply with these requirements to maintain their contracts with public purchasers.
- There is the potential to reduce costs by reducing medical errors, complications, and readmissions. This is particularly important in the context of value-based reimbursement and accountable care organizations (ACOs).

Logic Model for Implementation of the National CLAS Standards Within the Hospital Setting

Figure 4.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the hospital setting. Given the importance of the broader context and external resources and partnerships to shape a hospital's readiness for adopting the National CLAS Standards, we include them in the context, antecedents, and inputs column and note that any changes should be made in partnership with the community and other stakeholders.

Context, Antecedents, and Inputs

Linkages with the Community and Other Stakeholders

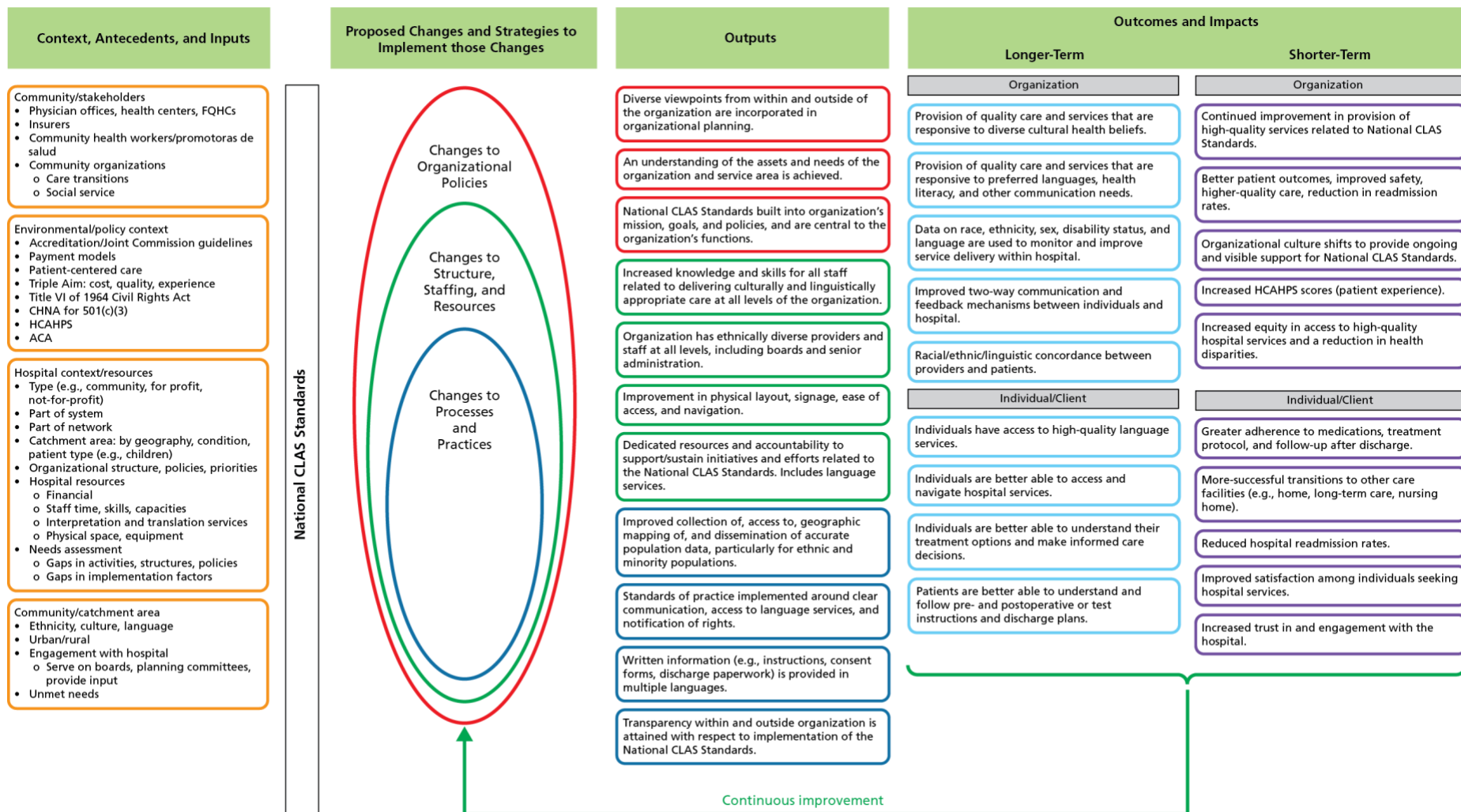
Hospitals have a number of collaborative relationships and partnerships with community entities to understand and address the cultural and linguistic needs of the communities they serve (Wilson-Stronks and Galvez, 2007; Weech-Maldonado and Merrill, 2000). These partnerships include educational, social service, religious, and public health organizations, as well as other hospitals and providers who may provide specialty care for their patients. For example, hospitals may work with alternative medicine providers to augment allopathic treatments and avoid complications from incompatible therapies (Brach and Fraser, 2000). Such linkages may also include liaisons with trusted members of the community, such as community health workers or *promotores de salud* (Rural Health Information Hub, 2017; Lewin Group, 2002; Brach and Fraser, 2000). Furthermore, hospitals may have a direct presence in the community through hospital-owned primary care practices. These linkages are particularly important as hospitals seek to improve transitions in care for patients discharged from the hospital, with the goal of reducing readmissions and unnecessary emergency department utilization. In addition, these linkages are critical given the emergence of ACOs, where hospitals are assuming risk for the episode of care. This has increased the focus of hospitals on population health and the social determinants of health and has resulted in an increased awareness of the importance of community linkages.

Hospitals may also be connected to other provider stakeholders (e.g., physicians and other health care providers) through ACOs. ACO arrangements focus on forming provider networks to coordinate care delivery. Because ACOs may be rewarded based on their ability to improve quality and reduce costs, implementing the National CLAS Standards may provide an opportunity to reach these goals (Adepoju, Preston, and Gonzales, 2015). Hospitals should consider how they work with partners and contracted organizations with respect to meeting the diverse cultural and linguistic needs of their patient populations because this may influence their own overall performance with respect to the National CLAS Standards.

Other stakeholders include payers and employers. CLAS activities can improve quality and outcomes and lower costs of care that patient insurers and/or employers pay. As such, both

insurers (e.g., health plans) and employers can be partners in hospital efforts to increase cultural competency and other CLAS activities within the hospital or in the surrounding community. Such partners should be involved at all stages of National CLAS Standards adoption (e.g., assessment, design, implementation, evaluation).

Figure 4.1. Logic Model for Implementation of the National CLAS Standards Within the Hospital Setting



Environmental and Policy Context

Implementation of the National CLAS Standards within an organization is affected by a number of factors external to the organization itself. These include, for example, the federal (e.g., the Affordable Care Act [ACA]), state, tribal, and local regulatory environments; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may impact whether and how organizations may choose to adopt the National CLAS Standards.

One external factor that can affect implementation is the ACA, which contains several provisions related to providing culturally and linguistically appropriate care. In addition, under Title VI of the Civil Rights Act of 1964 (Chen, Youdelman, and Brooks, 2007), organizations receiving federal funds must take reasonable steps to provide meaningful access to their programs for individuals with LEP (Federal Register, 2000). Furthermore, several states have recognized the importance of cultural and linguistic competency by legislating cultural and linguistic competency training in health care (U.S. Department of Health and Human Services [HHS] Office of Minority Health [OMH], 2016b). Accrediting bodies, such as the JCAHO and the National Committee for Quality Assurance, have also established accreditation standards that target the improvement of communication, cultural competency, patient-centered care, and the provision of language assistance services (Briefer French et al., 2008; HHS OMH, 2013; Wilson-Stronks and Galvez, 2007).

In addition to changes in the regulatory environment, hospitals are also working within changes in payment models toward more value-based purchasing and toward an increasing emphasis on population health, which align with the National CLAS Standards. Related to this are the various financial penalties and rewards associated with performance on publicly reported measures, such as readmissions and patient experience.

These types of external influences and contexts may impact whether and how a hospital will adopt the National CLAS Standards and how easy or difficult such implementation may be for the hospital.

Hospital Context, Resources, Community, and Catchment Area

Inputs and antecedents relevant to the implementation of the National CLAS Standards can vary considerably depending on the type of hospital (e.g., public, for profit, not for profit) and on whether the hospital is part of a system (e.g., a group of hospitals) or network. Inputs and antecedents—such as the hospital’s strategic goals, policies, staff, resources, and physical environment—may also be driven by the catchment area of the hospital and whether that hospital serves a geographic area or a specific population (e.g., children) or is disease-specific (e.g., cancer center).

Other factors influencing hospital inputs and antecedents include both internal and external elements. Internal factors—such as payer mix, the proportion of inpatients with Medicare, Medicaid, or private insurance, or the proportion uninsured—can affect resource availability.

External factors, such as competition, can provide an impetus for cultural competency activities as hospitals strive to increase or maintain their market share in areas with an increasingly diverse population. Weech-Maldonado and colleagues (2012c) found that hospitals in more-competitive markets had a higher degree of adherence to culturally and linguistically appropriate care.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven, for example, by a gap analysis or needs assessment. This analysis should include an assessment of activities, structures, or policies that should be in place to support equitable care as well as implementation factors that could aid or hinder the adoption of the National CLAS Standards. Of note, all not-for-profit hospitals are required to complete a community health needs assessment (CHNA) and implementation strategy (CDC, 1987). These assessments and strategies are intended to help hospitals obtain the information they need to provide benefits that better meet the needs of their communities and to provide an opportunity for coordination with other community services (CDC, 1987). Although not all hospitals are required to complete a CHNA, those that do may use such information to inform the adoption and implementation of the National CLAS Standards.

National CLAS Standards

As with the other logic models, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Again, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted and help to shape the activities that the organization chooses to implement to address gaps in culturally and linguistically appropriate care within its setting.

Proposed Changes and Strategies Developed to Implement Those Changes

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must plan and design relevant activities and approaches to close these gaps. As was noted in earlier chapters in this report, organizations may adopt the National CLAS Standards either altogether or in a staged approach, depending on the antecedents and inputs, readiness for National CLAS Standards implementation, and the environmental and policy context. Given the wide range of potential approaches and activities a hospital may choose to develop or adopt, the logic model does not include specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices. The identification of gaps and priorities and the design and development of activities to address those gaps are expected to be done in close collaboration with the community and other stakeholders that stand to benefit from such changes.

Outputs

The activities and changes implemented within the organization should result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include the following:

- incorporating diverse viewpoints from inside and outside the hospital into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the hospital's mission, goals, and policies and making them central to its functions
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse health care practitioners and staff at all levels of the hospital
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- targeting quality improvement (QI) activities to disparities in access and outcomes of care
- ensuring that resources and accountability to support and sustain initiatives and efforts related to the National CLAS Standards are available.

The specific outputs expected will be determined by which of the National CLAS Standards have been adopted, by which organizational changes have been made, and by which activities have been implemented as a result.

Outcomes

Collectively and over time, outputs from hospitals may contribute to changes in outcomes both for individuals using inpatient services and for the hospital overall. Examples of potential outcomes within the hospital setting are listed below.

- Outcomes for the organization:
 - Short term (1–2 years)
 - the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
 - the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve service delivery within the hospital
 - improved two-way communication and feedback mechanisms between individuals and hospitals
 - racial/ethnic and linguistic concordance between providers, hospital staff, and patients
 - increased linkages with community stakeholders, with a focus on social determinants of health

- Longer term (3 or more years)
 - continued improvement in the provision of high-quality services related to the National CLAS Standards
 - better patient outcomes, improved safety, higher-quality care, and a reduction in readmission rates
 - reduced hospitalizations for ambulatory-sensitive conditions
 - organizational culture shifts to provide ongoing and visible support for the National CLAS Standards within the hospital
 - increased HCAHPS scores (patient experience)
 - increased equity in access to high-quality hospital services and a reduction in health disparities.
- Outcomes for the individuals seeking care:
 - Short term (1–2 years)
 - access to high-quality language services
 - increased ability to access and navigate hospital services
 - increased ability to understand treatment options and make informed care decisions
 - ability to understand and follow pre- and post-operative or test instructions and discharge plans
 - connection with community resources to facilitate transitions in care
 - Longer term (3 or more years)
 - greater adherence to medications, treatment protocols, and follow-up after discharge
 - more-successful transitions to other care facilities (e.g., home care, long-term care, nursing home care)
 - reduced hospital readmission rates and reduced admissions for ambulatory-sensitive conditions
 - improved satisfaction among individuals seeking hospital services
 - increased trust in and engagement with the hospital.

Quality Improvement

The logic model also depicts the adoption and implementation of the National CLAS Standards as a continual process, requiring a QI loop in which outputs and outcomes inform the development of future hospital actions, policies, or programs to better align with the National CLAS Standards. Culturally competent QI tailors care to address the specific language and culture barriers, which both helps to reduce disparities and can improve care for everyone (Green et al., 2010). When assessing the impact of the implementation of the National CLAS Standards and informing next steps, it is important that QI improvements be viewed specifically through a culturally competent lens.

Chapter Five. Behavioral Health Logic Model

Behavioral health refers to mental and emotional well-being and/or actions that affect wellness. It includes mental and substance use disorders. Services for behavioral health are somewhat unique in that they can be provided in a range of health care settings, including inpatient psychiatric hospitals, psychiatric units of general acute care hospitals, inpatient residential treatment facilities, day treatment programs, individual provider or group behavioral health practices, community mental health centers, and rehabilitation programs. Increasingly, behavioral health services are also being provided in the general medical and primary care sector, such as outpatient or ambulatory care clinics, physician offices, or community health centers (U.S. Department of Health and Human Services [HHS], 2001).³

In addition, behavioral health care can be provided by a diverse set of providers, including specialty providers (e.g., psychiatrists, psychologists, and psychiatric nurses) and licensed clinical therapists, social workers, counselors, and nurses who have received specialized training in treating behavioral health concerns. Providers with training in general health care, such as internists, family practitioners, pediatricians, physician assistants, and nurse practitioners, may also provide mental health and substance abuse services as part of routine care. Although behavioral health services are increasingly provided in ambulatory care settings (ACSs), the logic model described in this chapter focuses specifically on those settings that provide specialty care for behavioral health. In 2010, there were 10,374 specialty mental health treatment facilities and 13,339 specialty substance abuse treatment facilities in the United States.

In the United States, mental and substance use disorders are among the top conditions that cause disability and carry a high burden of disease. According to SAMHSA, by 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability (SAMHSA, 2016b). In 2014, an estimated 9.8 million U.S. adults (ages 18 and older) had a serious mental illness, with 15.7 million adults and 2.8 million youth (ages 12 to 17) having had a major depressive episode during the past year (SAMHSA, 2012). In addition, an estimated 22.5 million Americans ages 12 and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year (SAMHSA, 2016b). Despite this high prevalence, nearly 60 percent of adults with a mental illness and 90 percent of people with a substance use disorder do not receive the care they need (National Alliance on Mental Illness, undated; Sebelius, 2013).

³ The human services sector (e.g., social welfare, including housing, transportation, and employment; criminal justice; educational, religious, and charitable services) also delivers mental health services in a range of settings, including in the home, in the community, and in institutions. There is also the voluntary support network largely found in the community, which includes self-help groups and organizations devoted to education, communication, and support (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

In the United States, minority and low-income groups, as well as those living in rural areas, are more likely to have unmet behavioral health needs (National Institute of Mental Health [NIMH], undated; Agency for Healthcare Research and Quality [AHRQ], 2013a). Studies have shown, for example, that members of racial and ethnic minority groups are less likely to have access to mental health services (Wang et al., 2005) and less likely to seek or use community mental health services, compared with the general U.S. population (Samnaliev, McGovern, and Clark, 2009; Mulia, Tam, and Schmidt, 2014; Alegria et al., 2008). Minorities who do seek services for behavioral health conditions are more likely to receive lower-quality care (e.g., misdiagnoses [Alegria et al., 2008]) and are less likely to adhere to treatment plans (HHS, 2001). Although changes in how and where behavioral health care is delivered (e.g., primary care, telemedicine) and in who is delivering it may help address some of the current disparities in behavioral health care, significant work remains; this concern prompted NIMH to include mental health disparities as a cross-cutting research theme in its 2015 Strategic Plan for Research (NIMH, 2015).

Addressing disparities in behavioral health can be particularly challenging given the stigma surrounding it, as well as personal or cultural beliefs around the causes and treatment of mental health concerns. Communicating behavioral health symptoms, including thoughts and feelings, can also be challenging, particularly if there are cultural differences or language barriers between individuals and providers. Improving culturally and linguistically appropriate services within behavioral health settings may help reduce health inequities by improving the likelihood of help-seeking behaviors, improving perceptions about the value of behavioral health services and the likelihood of receiving high-quality care, improving communication and adherence to treatment protocols, and increasing patient satisfaction (Barksdale et al., 2012).

Logic Model for Implementation of the National CLAS Standards Within the Behavioral Health Setting

Figure 5.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the behavioral health setting. Given the importance of the broader context, external resources, and partnerships in shaping a behavioral health provider's readiness for adopting the National CLAS Standards, we include these items in the context, antecedents, and inputs section. Any changes should be made in partnership with the community and other stakeholders.

Context, Antecedents, and Inputs

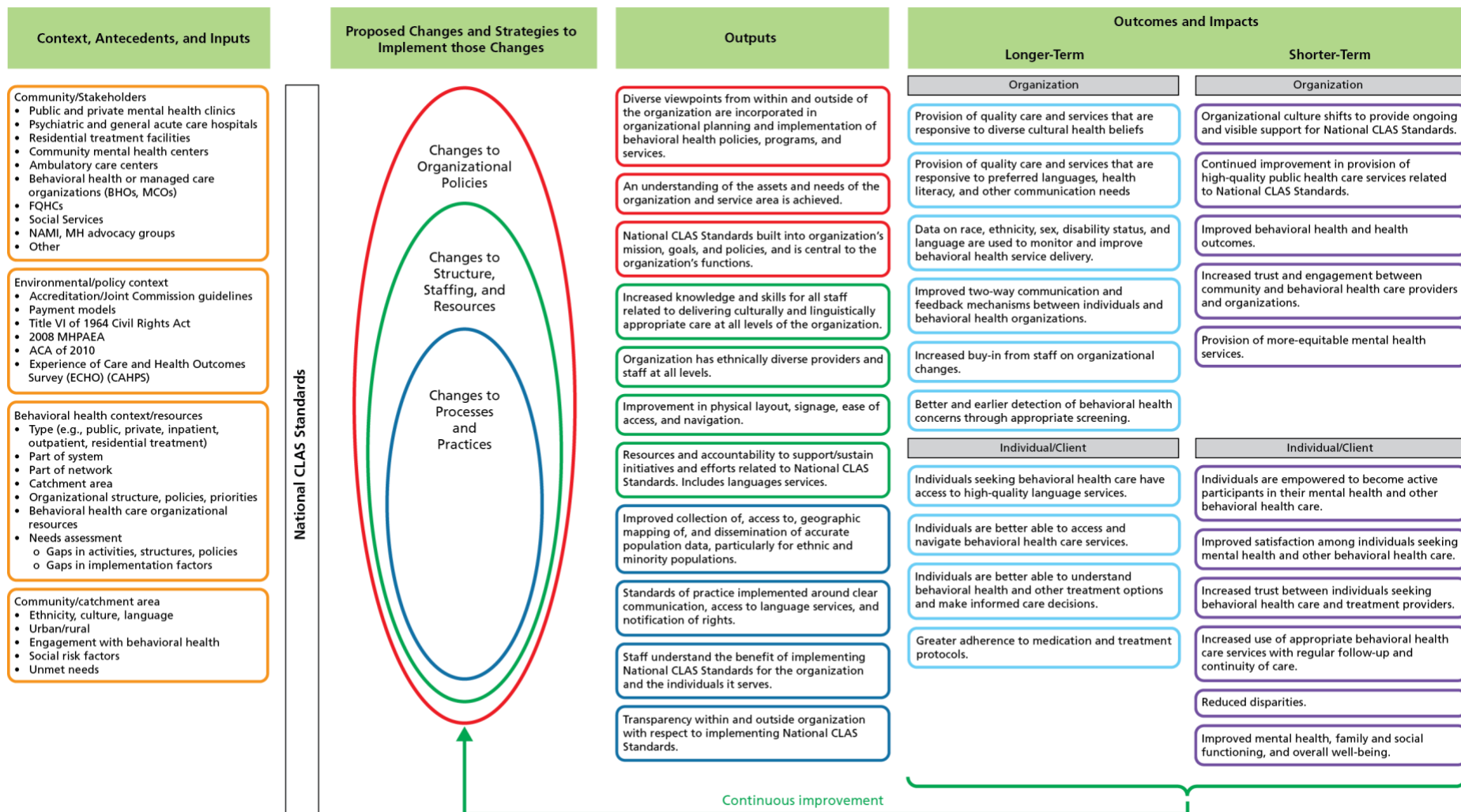
Linkages with the Community and Other Stakeholders

As shown in Figure 5.1, linkages with the community and other stakeholders who can inform, support, and partner with the behavioral health organization at all stages in the process of

adopting the National CLAS Standards (e.g., assessment, design, implementation, evaluation) are essential. In addition to engaging with other care settings that provide behavioral health services (e.g., ACSs and hospitals), other community sectors and settings provide services and supports that can supplement behavioral health services. For example, social welfare systems (e.g., housing, transportation, employment) and the criminal and juvenile justice systems help individuals connect to care. These may be particularly important partners because they also serve individuals who may be more likely to have unmet behavioral health needs. Schools may be another important community stakeholder and partner, particularly for reaching children and families. Charitable and faith-based organizations, voluntary support networks (e.g., self-help groups), and advocacy groups are also important stakeholders because they are often trusted organizations that are well integrated into the community and may offer education, communication assistance, and support (SAMHSA, 2012). Given this diversity, behavioral health organizations should consider how they work with their partners, with community organizations, and with contracted organizations: doing so may influence their overall performance with respect to implementing the National CLAS Standards.

Payers are another example of key stakeholders for behavioral health settings. Publicly funded sources—Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and other federal and state mental health authorities—are the predominant payers of behavioral health services in the United States. Together, these payers contributed more than \$75.4 billion in 2003, or about 62 percent of total behavioral health spending. At 26 percent, Medicaid represented the largest payer of behavioral health services (Medicaid and CHIP Payment and Access Commission [MACPAC], 2015). Of the public payers, states pay for behavioral health services through state appropriations for non-Medicaid services, block grant spending, and the state’s match for Medicaid and SCHIP programs. For fiscal year 2003, the states’ share of total behavioral health spending was \$42.3 billion, or 35 percent of total spending among all payers, while private insurance represented 21.8 percent of behavioral health expenditures (Schwalbe, 2010).

Figure 5.1. Logic Model for Implementation of the National CLAS Standards Within the Behavioral Health Setting



Environmental and Policy Context

Implementation of the National CLAS Standards within a behavioral health organization is affected by a number of factors external to the organization itself. These factors include, for example, the federal, state, and local regulatory environments; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may affect whether and how organizations may choose to adopt the National CLAS Standards.

In 1996, Congress enacted the Mental Health Parity Act (MHPA), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, or the federal parity law) generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less-favorable benefit limitations on those benefits than on medical/surgical benefits. The changes made by MHPAEA consisted of new standards, including parity for coverage of substance use disorder benefits and amendments to the existing mental health parity provisions enacted in MHPA.⁴

Of particular importance is the Affordable Care Act (ACA), which represented a significant expansion of mental health and substance use disorder coverage. The ACA amended the MHPAEA—which originally applied to group health plans and group health insurance coverage—so that it also applied to individual health insurance coverage. Additionally, beginning in 2014, the ACA required non-grandfathered individual and small-group plans (including those in the state and federal marketplaces) to provide coverage for mental health and substance use disorder services as one of ten essential health benefit categories and to cover them at parity with medical and surgical benefits. It is estimated that through the ACA, 32.1 million Americans would gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and that an additional 30.4 million Americans who currently have some mental health and substance use disorder benefits will benefit from the federal parity protections (Beronio et al., 2013). HHS has jurisdiction over public-sector group health plans (referred to as “non-federal governmental plans”), while the U.S. Departments of Labor and the Treasury have jurisdiction over private group health plans.

⁴ The Centers for Medicare & Medicaid Services’ (CMS’s) mental health and substance use disorder parity final rule for Medicaid and the Children’s Health Insurance Program (CHIP) applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP. Specifically, the final rule requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

There are also various existing cultural competency guidelines that have been developed for the behavioral health sector, two of which we highlight here. First, the American Psychological Association's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* provide the rationale and the background information that support the Association's six guidelines, as well as resources to enhance education, training, research, practice, and organizational change methodologies (American Psychological Association, 2002). Of particular relevance are Guideline 5, which addresses applying culturally appropriate skills in clinical and other applied psychological practices, and Guideline 6, which encourages psychologists to use organizational change processes to support culturally informed organizational policies and practices. SAMHSA (2015) also provides guidance on applying cultural competence in each step of its *Strategic Prevention Framework*.⁵ These guidelines are similar to the National CLAS Standards in their fundamental principles; however, the National CLAS Standards outline specific action steps that health organizations or health care organizations, including behavioral health care organizations, can undertake to implement culturally and linguistically appropriate services. The National CLAS Standards are intended to help organizations operationalize cultural and linguistic competency principles and implement them in their overall organizational culture (Barksdale et al., 2012).

These examples of external influences and contexts may impact whether and how behavioral health settings will adopt the National CLAS Standards and how easy or difficult such implementation may be.

Context, resources, community, and catchment area inputs and antecedents relevant to implementation of the National CLAS Standards for behavioral health organizations include the organization's strategic goals, policies, staff, resources, and physical environment. They can vary considerably depending on the type of behavioral health setting (e.g., public, for profit, not for profit) and on whether the behavioral health organization is part of a system or network (e.g., behavioral health managed care network). Inputs and antecedents such as the behavioral health organization's strategic goals, policies, staff, resources, and physical environment may also be driven by the catchment area of the facility and whether that facility serves a geographic area or a specific population (e.g., low-income populations, racially/ethnically diverse populations) or is focused on mental health treatment services, substance abuse treatment services, or both. Other factors influencing the organization's inputs and antecedents include internal and external factors. Internal factors—such as the proportion of patients with Medicare, Medicaid, or private insurance as well as the uninsured—can affect resource availability. External factors, such as competition, can provide an impetus for cultural competency activities as behavioral health

⁵ SAMHSA's framework draws on the 2005 guidance of the National Center for Cultural Competence at Georgetown University's Center for Child and Human Development, which outlines the characteristics of culturally competent organizations and describes the six stages of infusing cultural and linguistic competence in health promotion training (National Center for Cultural Competence, undated).

organizations strive to increase or maintain their market share in an increasingly diverse population.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven by a gap analysis or a needs assessment. This analysis should include both an assessment of activities, structures, or policies that should be in place to support equitable care and an assessment of implementation factors that could aid or hinder the adoption of the National CLAS Standards. A behavioral health needs assessment may also identify gaps in a community's mental health and substance use services system for those who do not speak English, helping to inform the prioritization of strategies and activities to address needs in the community.

National CLAS Standards

In this logic model, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Here, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted, and they help to shape the activities that the organization chooses to implement to address gaps in culturally and linguistically appropriate care.

Proposed Changes and Strategies Developed to Implement Those Changes

Behavioral health organizations may adopt the National CLAS Standards altogether or in a staged approach, depending on the antecedents and inputs, readiness for implementation, available resources, and the environmental and policy context. Given the wide range of potential approaches and activities that behavioral health organizations may choose to develop or adopt, the logic model does not list specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices. The identification of organizational gaps in meeting the National CLAS Standards; identification of priorities; and the design, development, and implementation of activities to address those gaps are expected to be done with input from, and in close collaboration with, the community and other stakeholders that stand to benefit from such changes.

Outputs

The activities and changes implemented within the organization should result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include the following:

- incorporating diverse viewpoints from inside and outside the behavioral health organization into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the organization's mission, goals, and policies and making them central to its functions

- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse practitioners and staff at all levels of the behavioral health organization
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain initiatives and efforts related to the National CLAS Standards are available.

The specific outputs expected will be determined by which of the National CLAS Standards have been adopted, by which organizational changes have been made, and by which activities have been implemented as a result.

Outcomes

Collectively and over time, outputs from behavioral health organizations may contribute to changes in outcomes for both individuals using these services and for the organization overall. Examples of potential outcomes within the behavioral health setting are listed below.

- Outcomes for the organization:
 - Short term (1–2 years)
 - the provision of effective, equitable, understandable and respectful quality care and behavioral health services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
 - the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve behavioral health service delivery
 - racial/ethnic and linguistic concordance between behavioral health service providers and individuals seeking mental health and/or substance use treatment services
 - improved two-way communication and feedback mechanisms between individuals and behavioral health organizations
 - increased buy-in from staff on organizational changes made to implement the National CLAS Standards
 - Longer term (3 or more years)
 - organizational culture shifts that provide ongoing and visible support for the National CLAS Standards within behavioral health care organizations
 - continued improvement in the provision of high-quality behavioral health care services related to the National CLAS Standards
 - improved behavioral health and health outcomes
 - increased equity in access to high-quality behavioral health services and a reduction in health disparities

- increased trust and engagement between the community and behavioral health care providers and organizations.
- Outcomes for the individuals seeking care:
 - Short term (1–2 years)
 - access to high-quality language services for individuals seeking specialty behavioral health care
 - ability to access and navigate specialty behavioral health care services
 - ability to understand mental health and other treatment options and make informed behavioral health care decisions
 - greater adherence to medication and treatment protocols
 - Longer term (3 or more years)
 - empowerment to become active participants in behavioral health care
 - improved satisfaction among individuals seeking mental health and other behavioral health care
 - increased trust between individuals seeking behavioral health care and providers and between the community and behavioral health care organizations
 - increased use of appropriate behavioral health care services with regular follow-up and continuity of care
 - improved behavioral health, family and social functioning, and overall well-being.

Quality Improvement

The logic model also depicts the adoption and implementation of the National CLAS Standards as a continual process, requiring a quality improvement (QI) loop. For example, behavioral health organizations can assess their performance by applying for Behavioral Health Accreditation (the Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2007), psychologists can assess how well they are following the American Psychological Association Guidelines, and consumers can provide feedback on their experiences with behavioral health treatment using the Experience of Care and Health Outcomes (ECHO) survey.⁶ All of these tools may be helpful to assess the success and effectiveness of the implementation of the National CLAS Standards.

⁶ Similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that asks consumers and patients to report on and evaluate their experiences with health care, the ECHO survey asks for consumers' assessments about their behavioral health treatment, including mental health and chemical dependency services. The ECHO survey asks health plan enrollees about their experiences with behavioral health care and services provided by either managed behavioral health care organizations (MBHOs) or managed care organizations. It is designed for use by consumers, clinicians, MBHOs, health care plans, purchasers, states, and federal agencies. The ECHO survey's contents were largely derived from two preexisting instruments for behavioral health care quality assessment: the Mental Health Statistics Improvement Program and the Consumer Assessment of Behavioral Health Services surveys (AHRQ, 2016).

Chapter Six. Public Health Logic Model

The field of public health encompasses local health departments, local boards of health, tribal health departments, and other local government organizations that are responsible for providing essential public health services within a specific jurisdiction (Centers for Disease Control and Prevention [CDC], 2017). Together, these agencies are often referred to as local health departments (LHDs). LHDs play a critical role in monitoring community health, informing and educating the public about health, mobilizing community partnerships, and developing policies and plans that support individual and community health efforts (CDC, 2016a). In particular, there are three core functions of public health around which LHDs often organize their work (CDC, 2017):

1. linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable
2. ensuring a competent public and personal health care workforce
3. evaluating the effectiveness, accessibility, and quality of personal and population-based health services.

The National CLAS Standards are in alignment with and have the potential to further strengthen each of these core functions (see Table 6.1). Given their focus on population health, LHDs serve individuals from a variety of cultural and linguistic backgrounds. As a result, the National CLAS Standards are particularly relevant to LHDs.

Table 6.1. Linking the National CLAS Standards to Core Public Health Functions

Core Public Health Function	Role of the National CLAS Standards
Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable	Ensure that the provision of health care—provided by LHDs or organizations partnering with LHDs—is culturally and linguistically appropriate
Ensuring a competent public and personal health care workforce	Ensure workforce competencies, including cross-cultural communication skills and the ability to communicate (alone or through a translator) in ways that individuals can understand
Evaluating the effectiveness, accessibility, and quality of personal and population-based health services	Ensure data collection, including data on cultural subgroups, such as race/ethnicity, language preferences, education, and income of patients, to ensure that evaluations capture cultural and linguistic differences

Despite the natural alignment between the National CLAS Standards, the core functions of public health, and the populations that LHDs commonly serve, the acceptance of the National CLAS Standards by LHD leadership differs across jurisdictions. These differences may be based on a range of characteristics unique to each LHD and the perceived needs of the population served (see Table 6.2). For example, LHDs often already include professionals who reflect the

populations they serve. This means that they may have critical cultural and language competencies and they may be more sensitive to the diversity of the populations they serve. Training on cultural and linguistic appropriateness of care is increasingly offered as part of formal public health schooling, embedded in existing public health staff training, and required by some states (e.g., Maryland). As a result, LHDs may have different perceptions of the added value of the National CLAS Standards relative to their current standards of practice.

Table 6.2. Diverse LHD Organizational Arrangements

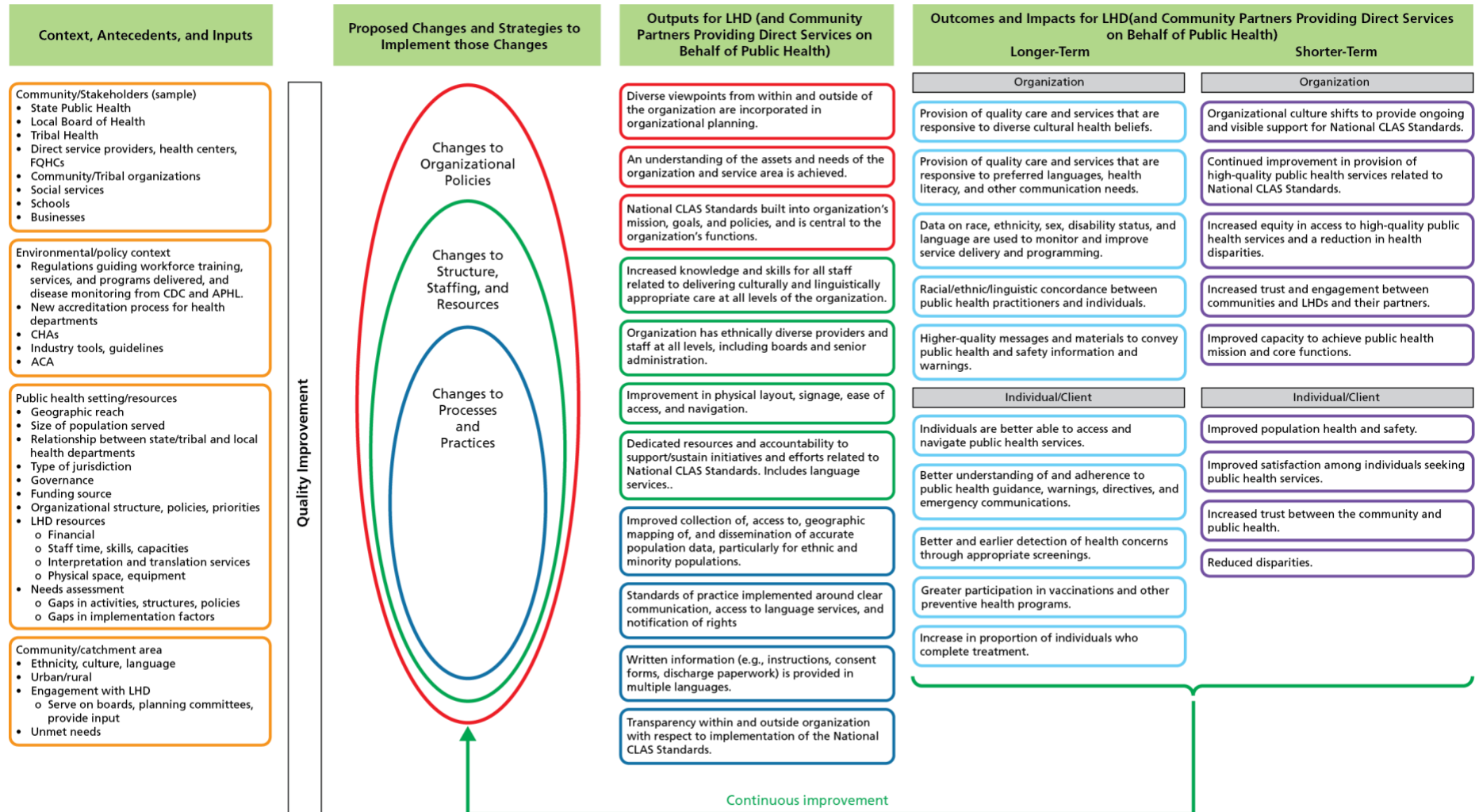
Characteristic	Details
Geographic reach	LHDs can serve communities at the local, state, tribal, and/or regional level. Some states have no local public health agencies and rely on LHDs with larger catchment areas.
Size of population served	The size of the population served varies considerably, with 43 percent of LHDs serving populations of 25,000 or less and 5 percent serving populations of 500,000 or more.
Relationship between state health department, tribal health department, and LHD	Services offered can be centralized, decentralized, or hybrid; centralized services are provided by a state health department and are coordinated by local offices, while decentralized services are planned and provided by local agencies.
Type of jurisdiction	The type of jurisdiction varies considerably and can include county, city/county, township, multi-county/district/regional, city, and tribal communities.
Governance	A board of health may serve in a policymaking capacity or an advisory capacity only.
Funding sources	The combination of funding sources varies by LHD and may include local contributions, state contributions, federal pass-through funding, Medicaid and Medicare reimbursements, and fees.
Size of staff, budget, type of health care services provided	These vary considerably.

NOTE: Adapted from data provided in Brownson et al., 2012.

Logic Model for Implementation of the National CLAS Standards Within the Public Health Setting

Figure 6.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the public health setting. Given the importance of the broader context and external resources and partnerships to shape a public health setting's readiness for adopting the National CLAS Standards, we include them in the context, antecedents, and inputs section. Any changes should be made in partnership with the community and other stakeholders.

Figure 6.1. Logic Model for Implementation of the National CLAS Standards Within the Public Health Department Setting



Context, Antecedents, and Inputs

Linkages with the Community and Other Stakeholders

Successful implementation of the National CLAS Standards requires clear and meaningful linkages between LHDs, the community, and relevant stakeholder groups in every step of the process to understand and address the cultural and linguistic needs of the communities served (Wilson-Stronks and Galvez, 2007; Weech-Maldonado and Merrill, 2000). LHDs are increasingly focused on developing partnerships with community and faith-based organizations (CFBOs) to mitigate the negative consequences of economic changes on their budgets and to leverage greater assets in community health promotion. Partnerships between LHDs and CFBOs likely increase the capacity of LHDs to provide public health services (Wholey, Gregg, and Moscovice, 2009) and can expand the reach of LHD activities into communities that are marginalized because of cultural divisions and a lack of resources. CFBOs are a critical component to public health systems (Mays, Halverson, and Scutchfield, 2003). They often have the capabilities needed to provide public health interventions and are trusted resources in their communities (Acosta et al., 2011). CFBOs share an interest in population health and well-being and can bring community knowledge to the table, improve trust in governmental public health, and make the work of public health more transparent and understandable. The development of partnerships and coalitions has been evident in most public health program areas, such as maternal and child health, HIV/AIDS, and chronic disease prevention.

In this section, we focus on the role of LHDs in implementing the National CLAS Standards and in coordinating with a range of stakeholders. Some LHDs provide direct services (e.g., immunizations, screenings, and treatment for tuberculosis and sexually transmitted diseases) at public health centers and through community clinics. LHDs may also provide inpatient care through public hospitals. In other places, they do not provide services directly, instead developing formal and informal partnerships to provide care for the most vulnerable. The most formal of these partnerships are contracts to provide services. In these cases, the National CLAS Standards are relevant both to the LHD and to its community partners. In health care, these partners include ambulatory care clinics that may screen for infectious diseases and provide vaccinations. As a result, LHDs must consider how they work with partners and contracted organizations to implement the National CLAS Standards because this will influence their performance with respect to meeting the cultural and linguistic needs of the individuals they serve. Primary care and inpatient providers are also obligated to report certain conditions to LHDs. For example, in California, providers must report a large number of communicable diseases, HIV, outbreaks of any condition or disease, the occurrence of any unusual disease, and some noncommunicable conditions or diseases (California Department of Public Health, 2016). Other entities provide substance abuse treatment, maternal and child health services, environmental health services, and communicable/infectious disease and chronic disease

programs (National Association of County and City Health Officials [NACCHO], 2014). LHDs engage many different partners inside and outside the health care system, including schools, media, local businesses, faith-based organizations, and other community-based organizations (NACCHO, 2009).

LHDs' links to outside partners provide opportunities for formal and informal dissemination of the National CLAS Standards. There are several mechanisms through which this might occur. LHDs are part of a rich network of organizations in the community that are aligned toward the same population health goals, including health care clinics and mental health and substance abuse treatment centers, as well as organizations that provide specialty services to persons with specific conditions, such as HIV. Dissemination of the National CLAS Standards within public health organizations could increase the likelihood that they are adopted by other organizations. LHDs sometimes have more-formal relationships with these organizations through memoranda of understanding and funding mechanisms. LHDs could thus exert financial pressure on partners to adopt the National CLAS Standards. In addition, LHDs could support the adoption of the National CLAS Standards within the community by disseminating toolkits and collecting and analyzing data that evaluate the impact of the National CLAS Standards in their communities.

Environmental and Policy Context

A number of factors external to the organization itself affect the implementation of the National CLAS Standards within an organization. These external factors include, for example, the federal (e.g., Affordable Care Act), state, tribal, and local regulatory environments; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may affect whether and how organizations choose to adopt the National CLAS Standards.

Within the public health setting, there are various requirements that regulate workforce training, services and programs delivered, and disease monitoring, including those from the Association of Public Health Laboratories and the CDC. To the extent that the National CLAS Standards align with or leverage these requirements, it will be easier for LHDs to implement them. In addition, there is a new accreditation process for public health departments. It is not required, and only a small portion of LHDs have completed the process (Public Health Accreditation Board, undated). However, several standards in the accreditation process are relevant to the National CLAS Standards. These may serve as a platform for increasing the implementation of the National CLAS Standards among LHDs as they move toward accreditation. The accreditation standards that most align with the National CLAS Standards include

- Standard 7.1: Assess Health Care Service Capacity and Access to Health Care Services
- Standard 7.2: Identify and Implement Strategies to Improve Access to Health Care Services

- Standard 8.1: Encourage the Development of a Sufficient Number of Qualified Public Health Workers
- Standard 8.2: Ensure a Competent Workforce Through Assessment of Staff Competencies, the Provision of Individual Training and Professional Development, and the Provision of a Supportive Work Environment.

These examples of external influences and contexts may affect whether and how an LHD will adopt the National CLAS Standards and how easy or difficult such implementation may be for the organization.

Public Health Context, Resources, Community, and Catchment Area

Inputs and antecedents relevant to the implementation of the National CLAS Standards include the organization's strategic goals, policies, staff, resources, and physical environment. Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven by a gap analysis or needs assessment.

Despite similar core functions, LHDs vary significantly with respect to reach, size, governance, jurisdiction, and funding sources—all of which are relevant inputs to adopting and implementing the National CLAS Standards (see Table 6.2).

One challenge is that LHDs are often constrained by the diversity of their arrangements because funding priorities are often set by external organizations, typically at the federal and state levels (NACCHO, 2006); by political mandates; and by natural population shifts. This means that LHDs often lack the internal capacity to allocate resources for implementing new initiatives. This problem may be exacerbated in smaller LHDs, where there are fewer overall resources. A recent review of the literature suggests that some characteristics, such as size of population served, budget, and governance, predict LHD performance (Hyde and Shortell, 2012). Adopting the National CLAS Standards within these different contexts may be complicated because it is not clear which mechanisms are related most closely to LHD decisionmaking and priority-setting. More importantly, the multiple demands on LHD priorities mean that it is likely that prioritization of the National CLAS Standards would have to come from multiple policymaking and funding authorities.

A final input worth noting is that a strength of many LHDs is population-level data collection and analysis. Given that a core function of public health is monitoring and evaluating the effectiveness, accessibility, and quality of personal and population-based health services, many LHDs have conducted community health assessments (CHAs). These assessments provide a more in-depth look into the health needs of the community and may identify key gaps in culturally or linguistically appropriate activities, structures, or policies. They may also include an analysis of implementation factors that could aid or hinder the adoption of the National CLAS Standards. LHDs conduct CHAs using such tools as Mobilizing for Action through Partnerships and Planning (NACCHO, 2016). CHAs and other existing data-collection efforts may be helpful inputs as LHDs look to adopt and implement the National CLAS Standards.

National CLAS Standards

In this logic model, the National CLAS Standards are placed between the antecedents and inputs and the activities that an organization adopts. Here, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted and help to shape the activities that the organization chooses to implement to address gaps in culturally and linguistically appropriate care within the public health setting.

Proposed Changes and Strategies Developed to Implement Those Changes

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must plan and design relevant activities and approaches to alleviate these gaps. Organizations may adopt the National CLAS Standards altogether or in a staged approach, depending on the antecedents and inputs, the organization's readiness for change, and the environmental and policy context. Given the wide range of potential approaches and activities that an LHD may choose to develop or adopt, the logic model does not list specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices.

Changes to organizational policies include making the National CLAS Standards central to the organization's functions and building them into the organization's mission, goals, and policies. One example of a potential policy is the provision of transportation for individuals who do not speak English well enough to safely and successfully navigate the public transit system. Engaging diverse viewpoints from inside and outside the organization into planning is particularly important. Building this orientation into the organization's approach is especially important when an LHD seeks to implement the National CLAS Standards among its community partners.

Changes to LHD organizational structure, staffing, and resources require that the LHD and its partners have identified the necessary skill set for their staff to address cultural and linguistic needs, have the capacity to train staff when necessary, and ensure retention and minimal turnover to help build trust and rapport with the community. In addition, the organization should be focused on diversifying its frontline staff and ensuring an ethnically diverse staff at all levels, including boards and senior administration, even in circumstances when its internal needs assessments lead it to implement a subset of the National CLAS Standards or within a limited set of LHD activities. This is particularly important given that LHD policies are set by a number of different bodies that sometimes include leadership outside the organization's own staff. Changes to organizational structure include making improvements in the ease of access to its physical space and to the information it provides to consumers through signage. In addition, the LHD would have dedicated resources to support and sustain the implementation of the National CLAS Standards, including language services and a process for holding itself and its partners accountable for these improvements.

Changes to processes and practices encompass all the unique functions of public health, including improved collection and access to population data, communicating complex health information that is actionable to everyone in the community, and providing access to this information in multiple languages using high-quality translations.

It is expected that the identification of gaps and priorities and the design and development of activities to address those gaps will be done in close collaboration with the community and other stakeholders that stand to benefit from such changes. Because of the varied and complex ways that public health can be organized, the results of these analyses will be very different. Many LHDs are uniquely positioned to draw out these lessons from stakeholders because of their long-standing partnerships, but not all LHDs are. Prioritizing the National CLAS Standards with respect to organizational policy, practice, staffing, and resources is critical to ensuring that every LHD, no matter the context, takes appropriate steps to ensure that its services are accessible by all members of the community.

Outputs

The activities and changes implemented within the organization should result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include the following:

- incorporating diverse viewpoints from inside and outside the LHD into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the organization's mission, goals, and policies and making them central to its functions
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse public health practitioners and staff at all levels of the LHD
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain initiatives and efforts related to the National CLAS Standards are available.

The specific outputs expected will be determined by which of the National CLAS Standards have been adopted, by which organizational changes have been made, and by which activities have been implemented as a result.

Outcomes

Collectively and over time, outputs from LHDs may contribute to changes in outcomes, both for individuals using public health services—regardless of whether they are provided directly by

the LHD or by a partner—and for the LHD overall. Examples of potential outcomes within the public health setting are listed below.

- Outcomes for the organization:
 - Short term (1–2 years)
 - the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
 - the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve public health service delivery
 - racial/ethnic and linguistic concordance between public health practitioners and individuals seeking services
 - higher-quality messages and materials to convey public health and safety information and warnings
 - Longer term (3 or more years)
 - organizational culture shifts that provide ongoing and visible support for the National CLAS Standards within LHDs and within community partners providing health-related services on behalf of the LHD
 - continued improvement in the provision of high-quality public health services related to the National CLAS Standards
 - increased equity in access to high-quality public health services and a reduction in health disparities
 - increased trust and engagement between the community, the LHD, and its partners
 - improved capacity to achieve the public health mission and its core functions.
- Outcomes for the individuals seeking care:
 - Short term (1–2 years)
 - increased ability to access and navigate public health services
 - increased ability to understand and adhere to public health guidance, warnings, directives, and emergency communications
 - better and earlier detection of health concerns through appropriate screenings
 - greater participation in vaccinations and other preventive health programs
 - Longer term (3 or more years)
 - improved population health and safety
 - improved satisfaction among individuals seeking public health services
 - increased trust between the community and public health organizations
 - reduced disparities.

Quality Improvement

The logic model depicts the adoption and implementation of the National CLAS Standards as a continual process, requiring a quality improvement (QI) loop. Many LHDs have assessed their own performance with such tools as the CDC's *National Public Health Performance Standards Program* and NACCHO's *Local Health Department Self-Assessment Tool*; these tools may be

helpful in assessing the success and effectiveness of the National CLAS Standards implementation. Furthermore, since 2003, there has been guidance for LHDs on developing organizational self-assessments, which measure culturally and linguistically appropriate services. As a result, LHDs are very familiar with self-monitoring for QI (COSMOS Corporation, 2003).

Chapter Seven. Evaluation Questions and Process Outcomes and Impact Measures

In earlier chapters, we presented both a conceptual framework and setting-specific logic models to help organizations begin to assess the extent to which the National CLAS Standards—and the related changes that HCOs put in place to address these them—result in an improved ability “to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” (Principal Standard, HHS OMH, 2013). In this chapter, we provide additional detail on key evaluation questions and measures that can be used as part of process and outcomes evaluations.

A *process evaluation* determines whether program or intervention activities (in this case, activities related to the National CLAS Standards) have been implemented as intended and have resulted in certain outputs. This type of evaluation informs one about the extent to which the proposed change (e.g., policy, training, intervention) is being implemented as designed; whether the change is working and reaching the intended audience; and what adjustments, if any, are needed. A process evaluation can also inform the results of outcomes or impact evaluations, helping to assess *why* the changes were or were not as successful as the organization had hoped.

An *outcomes evaluation* measures program or intervention effects by assessing the progress in the desired outcomes or outcome objectives (SAMHSA, 2016). An *impact evaluation* assesses overall program effectiveness in achieving its ultimate goals. *Outcome measures* typically reflect short- and intermediate-term results, whereas *impact measures* are the direct or indirect long-term effects or consequences of the outcomes (in terms of overall effectiveness or efficiency), resulting from achieving program or project objectives and goals (HHS OMH, 2010). We use the term *impact/outcomes evaluation* to include both short- and intermediate-term outcomes, as well as the longer-term effects of implementing the National CLAS Standards. Thus, the questions we developed below address both the process of implementing the National CLAS Standards and the results (impact and outcomes) of these changes or activities. In this chapter, we not only provide an overview of the evaluation questions developed to support the implementation of the National CLAS Standards within an HCO; we also include a number of key measures that organizations may wish to use to help answer these questions. These measures were selected both for their strong psychometric properties (e.g., reliability, validity) and because they are readily available or already collected as part of the organization’s ongoing QI or accreditation processes.

Evaluation Questions

To develop the list of process and impact or outcomes evaluation questions, we began with a literature review of assessments, tools, and resources for measuring cultural competence and access to linguistic services, both in general and specific to the four settings that are the focus of this project. Examples of key resources reviewed included

- the National Quality Forum's (NQF's) *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (NQF, 2009)
- NCQA's *Multicultural Health Care: A Quality Improvement Guide* (Briefer French et al., 2008)
- the Lewin Group's *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile* (Lewin Group, 2002)
- Weech-Maldonado and colleagues' "The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence (CC) Item Set" (Weech-Maldonado et al., 2012b)
- Diamond and colleagues' "Do Hospitals Measure up to the National Culturally and Linguistically Appropriate Services Standards?" (Diamond, Wilson-Stronks, and Jacobs, 2010)
- Weech-Maldonado and colleagues' "Cultural Competency Assessment Tool for Hospitals: Evaluating Hospitals' Adherence to the Culturally and Linguistically Appropriate Services Standards" (Weech-Maldonado et al., 2012a)
- The COSMOS Corporation's *Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies: Final Report* (COSMOS Corporation, 2003)
- SAMHSA's "Resources Related to Cultural Competence" (SAMHSA, 2016c)
- SAMHSA's "Appendix C: Tools for Assessing Cultural Competence" in *Improving Cultural Competence* (SAMHSA, 2014a).

We synthesized the results of the review and identified the evaluation questions that corresponded to different elements of the logic models. Our goal was to derive evaluation questions that address the process of an organization deciding to implement the National CLAS Standards, the planning for and implementation of activities to do so, the resulting outputs, and key outcomes and impacts to measure. We decided not to provide setting-specific questions because the questions themselves are quite universal, meaning that they can be used in any health setting and are relevant regardless of which National CLAS Standards are selected by an HCO for implementation. The evaluation questions are summarized below; they are divided into questions relevant for process evaluations and those more relevant for impact/outcomes evaluations.

Process Evaluation Questions

1. Is there an awareness of the National CLAS Standards?
 - a. What is the degree of awareness of the National CLAS Standards within the HCO or health care system?
 - b. How aware is the HCO or health care system about the accreditation or regulatory requirements that align with or can otherwise influence adoption of the National CLAS Standards?
 - c. To what degree does staff understand the benefits of implementing the National CLAS Standards—both for the organization and the individuals it serves?
2. Does the organization have a team tasked with addressing culture/language?
 - a. Which internal champions and internal stakeholders have been identified to help focus organizational efforts on providing culturally competent care?
 - b. Has the organization appointed one or more committees of internal and external stakeholders to oversee the design, planning, and implementation of CLAS-related activities in the following areas?
 - i. Governance, leadership, and workforce
 - ii. Communication and language assistance
 - iii. Engagement, continuous improvement, and accountability
 - c. To what extent have diverse viewpoints been incorporated in organizational planning and implementation of policies, programs, and services?
3. Does the organization have active and ongoing input from the community?
 - a. Have outside partners and/or community resources been identified by the HCO or health care system to support implementation of the National CLAS Standards?
 - b. Which community partners have been identified as important stakeholders for implementing the National CLAS Standards?
 - i. To what degree have these partnerships been formalized (e.g., memoranda of understanding)?
 - c. What community resources have been identified?
 - i. To what extent have community resources been committed to assist with implementation?
 - d. Which funders or funding agencies and accreditation agencies or bodies (e.g., JCAHO, NCQA) have been identified to help guide or support CLAS efforts within an organization?
4. Has the organization completed a needs assessment with respect to the National CLAS Standards?
 - a. Has an organizational self-assessment of current CLAS-related activities and gaps been conducted within the past two years?
 - i. If so, in what areas (e.g., accessibility of language services)?
 - b. To what extent do the National CLAS Standards align with the organization's or health care system's policies and practices that are already in place?

- c. To what extent are the organization's or health care system's current strategic priorities aligned with the National CLAS Standards?
- 5. Has the organization developed an implementation plan to address gaps and priorities identified?
 - a. What gaps have been identified, and what prioritization has been made?
 - b. What opportunities for improvement and actions have been identified to meet the National CLAS Standards?
- 6. Has the organization committed funds or resources for the proposed change?
 - a. To what extent have the needed resources (e.g., staff, funding) within the HCO or health care system and from the community been set aside or designated to implement the National CLAS Standards?
- 7. To what extent has the organization implemented its plan to address identified needs and gaps in culturally and linguistically appropriate services?
 - a. What changes in governance, leadership, and/or workforce have been made to facilitate implementation of the National CLAS Standards?
 - b. What changes in policies and organizational structures have been made to implement the National CLAS Standards?
 - c. What changes in human resource practices have been made to increase recruitment and retention of minorities at all levels of the organization?
 - d. Has a formal training program for staff on cultural and language diversity been implemented?
 - e. What improvements have been made to ensure access to accurate population data, particularly by race/ethnicity, primary language, and other minority status information?
- 8. To what extent does the organization collect and use data for CQI?
 - a. What CQI processes have been put into place?
 - b. What changes in data collection have been made to improve the collection of, access to, and dissemination of accurate population data to assess needs and progress made by the organization or health system in aligning its practices to the National CLAS Standards?

Outcomes Evaluation Questions

In the logic models, we identified the outcomes for both the short term and the longer term (at the organizational level and the client or individual level) as a result of the activities undertaken to implement the National CLAS Standards. The overarching outcomes question is whether the activities undertaken have resulted in changes in access, consumer experience, quality of care, and health outcomes. As noted earlier in this chapter, we made the distinction between short-term outcomes and longer-term outcomes and impacts. Specifically, questions identified for short-term outcomes include changes at the organizational or individual/client levels that one would expect to see within 1–2 years of implementation of the National CLAS Standards, such as improved access to high-quality language services. Questions related to

longer-term outcomes or impacts include changes at the organizational or individual/client levels expected to take 3 or more years to realize, such as shifts in organizational culture.

Below we summarize examples of the evaluation questions for each area.

Short-Term Outcomes

For organizations: To what extent has the implementation of the National CLAS Standards led or contributed to

1. the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve health service delivery?
2. improved two-way communication between providers and clients?
3. increased knowledge of culturally and linguistically appropriate care and buy-in from staff?
4. better and earlier detection of health care concerns through appropriate screening?

For clients/individuals: To what extent has implementation of the National CLAS Standards resulted in

1. improved access to high-quality language services for ethnic and minority populations?
2. consumers being better able to access and navigate health care services? If so, in what ways?
3. increased consumer understanding of health care treatment options and more-informed care decisions?
4. greater adherence to medication, treatment protocols, and follow-up visits?

Longer-Term Outcomes/Impacts

For organizations: To what extent has the implementation of the National CLAS Standards led to a cultural shift in the organization? To what extent has implementation led or contributed to

1. improvements in the provision of high-quality services for diverse populations?
2. improved health outcomes for ethnic and minority populations?
3. increased trust and engagement between patients and providers?
4. increased trust and engagement between the community and HCOs?
5. increased equity in access to health services?
6. a reduction in disparities in health outcomes?
7. increased capacity of the HCO or health system to address the needs of a diverse population?

For clients/individuals: To what extent has implementation of the National CLAS Standards led to

1. individuals feeling empowered to become active participants in their health care?
2. improved satisfaction among individuals seeking health care?
3. increased trust and engagement between individuals seeking care and treatment providers?

To what extent has implementation of the National CLAS Standards contributed to

1. increased use of appropriate health care services with regular follow-up and continuing of care?
2. increased equity in outcomes of health services?
3. improved health, family, and social functioning and overall well-being?

Process Outcomes and Impact Measures

Approach

Our literature search to develop the evaluation questions also identified a number of examples of process, outcomes, and impact measures. We augmented that literature review to include commissioned reports (e.g., NQF, 2012g); a search of peer-reviewed journal articles; and a search of guidance, reports, and measures provided on the websites of leading public entities (e.g., AHRQ, HRSA) and private entities, such as the NCQA and JCAHO. We also reviewed the 2014 Crosswalk between the National CLAS Standards and the JCAHO Hospital Accreditation Standards (The Joint Commission, 2014). In addition, OMH provided feedback to inform our search strategy. For example, a priority of OMH was that we include in our search reports by the NQF and reports relevant to the Cultural Competency Assessment Tool for Hospitals (CCATH) and local public health agencies in our search. We also included measures from CAHPS and HCAHPS in our review, given OMH's desire for RAND to leverage the CAHPS measures where possible.

Our overall approach was to identify a range of examples of measures for each setting, emphasizing well-constructed and validated measures with some or all of the following characteristics:

- assessed cultural competency
- captured language needs or preferences and/or linked to other CLAS-related issues
- documented disparities
- were widely used and plausible for use in a range of HCOs (e.g., small or large)
 - inclusive of measures that are used by several different quality reporting systems (e.g., sets of measures used by HRSA, NCQA, CMS)
- were previously endorsed in commissioned projects or reports for evaluating disparities
- were validated and/or psychometrically tested
- cut across conditions and/or across settings.

Although we included some process measures, our focus was on identifying outcome and impact measures relevant to evaluating the implementation of the National CLAS Standards. Wherever possible, we also sought to identify measures of short-term or intermediate outcomes of health care encounters with the HCO. The set of measures identified is intended to illustrate the key outcome and impact measures that are salient to the National CLAS Standards; it is not intended to be comprehensive. In addition, one of the objectives was to identify measures that would help

organizations move to a more consistent set of metrics to facilitate cross-site comparisons and meta-analyses.

It should be noted that for some types of HCOs or settings, well-validated or widely tested measures were scarce. In those cases, we identified the best measures that we could find that either had been validated to some extent and/or had good face validity. For example, in behavioral health, we were unable to find a validated measure of cultural competency and so note that there remains a need for the development of such a measure in this area.

We also sought to identify examples of disparity-sensitive measures for each setting that an HCO might use to assess how well it is doing in addressing identified disparities in outcomes. To identify disparity-sensitive measures, we drew on a number of sources, such as the *Healthcare Disparities and Cultural Competency Consensus Standards* project (NQF, 2012g), which identified disparity-sensitive measures among the existing NQF portfolio of endorsed measures; an NQF-commissioned paper by Weissmann et al. (2012) on health care disparities measurement; a 2008 NQF report, *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities*; and examples of recommended measures from SAMHSA’s National Behavioral Health Quality Framework (SAMHSA, 2014b). In addition, we reviewed the 2015 and 2016 lists of JCAHO Accountability Measures (Joint Commission, undated[a]), which, although not explicitly identified as disparity-sensitive, OMH and RAND agreed were important to include.⁷

Lastly, OMH desired a measure of workforce diversity that would enable HCOs to assess whether the diversity of their workforce (e.g., leadership [board, executive leadership, mid-management diversity] and clinical and frontline staff [e.g., the diversity of hospitals’ nursing staff and hospitalists]) matches the diversity in their organization’s patient population. We conducted a literature search on this topic and did not identify any standard measures of workforce diversity. However, we encourage HCOs to consider the metrics that might inform their understanding of how well their workforce represents the diversity seen in their patient population.

Measures Identified

Tables 7.1–7.5 present an overview of the identified measures (including measure title and general description), organized according to setting. If the measure is relevant to more than one setting, it is classified as cross-cutting. For each setting, we also include examples of disparity-sensitive measures that an HCO may use to assess how well it is doing in addressing identified disparities in outcomes. In Appendixes B–F, we provide further information about each measure, including the area of focus, the source, the wording of specific items, any relevant notes, and a reference to the measure set.

⁷ Specifically, we added information for hospitals about selected JCAHO accountability measures that we felt were particularly CLAS-salient (e.g., venous thromboembolism [VTE], immunization, substance abuse).

Table 7.1. Cross-Cutting Measures

Measure(s)	Description
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey (CG-CAHPS) that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of their provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CG-CAHPS. The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Patients receiving language services supported by qualified language services providers	This measure is used to assess the percentage of patients with limited English proficiency (LEP) receiving both initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers and bilingual workers/employees who have been assessed for language proficiency. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees during critical times in a patient's health care experience.
Screening for preferred spoken language for health care	This measure is used to assess the percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded. This measure provides information on the extent to which patients are asked about the language in which they prefer to receive care and the extent to which this information is recorded.
Cultural Competency Implementation Measure	<p>The Cultural Competency Implementation Measure is an organizational survey designed to assist HCOs in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey.</p> <p>Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.</p>
Communication Climate Assessment Toolkit (C-CAT)	<p>C-CAT, which has been extensively validated in diverse health care organizations nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices. When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment, conduct statistical analysis of data (including comparisons against a national benchmarking database), and create a feedback report featuring personalized, site-specific recommendations.</p> <p>In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it complements CAHPS assessments, documents compliance with Title VI culturally and linguistically appropriate services standards, and is invaluable in meeting JCAHO's patient-centered communication standards.</p>

Table 7.2. Ambulatory Care Measures

Measure(s)	Description
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Item Set	<p>CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Cultural Competence Item Set, a supplement to the CAHPS survey, is designed to capture the patient's perspective on the cultural competence of health care providers. The Cultural Competence Item Set covers the following topics: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; and linguistic competency (access to language services).</p> <p>In Weech-Maldonado et al. (2012b), measures are grouped into eight composites: doctor communication—positive behaviors; doctor communication—negative behaviors; trust; access to interpreter services; doctor communication—health promotion; doctor communication—alternative medicine; shared decisionmaking; and equitable treatment.</p>
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey (CG-CAHPS)	<p>CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.</p>
Disparity-sensitive measures or CLAS-salient measures	
Controlling high blood pressure	<p>The percentage of patients ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.</p>
Diabetes: hemoglobin A1c poor control	<p>The percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) whose most-recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.</p>
Uncontrolled diabetes admission rate	<p>Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 and older. Excludes obstetric admissions and transfers from other institutions.</p>
Diabetes short-term complications admission rate	<p>Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 and older. Excludes obstetric admissions and transfers from other institutions.</p>

Table 7.3. Hospital Measures

Measure(s)	Description
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS Hospital Survey or Hospital CAHPS, is a standardized survey instrument and data-collection methodology to measure patients' perspectives of hospital care. The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Health Literacy Set	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Hospital Survey (HCAHPS). The item set includes the following domains: information about medications, communication between nurses and patients, communication between doctors and patients, communication about tests, communication about forms, and information about how to care for yourself at home.
Cultural Competency Assessment Tool for Hospitals (CCATH)	The Cultural Competency Assessment Tool for Hospitals (CCATH) is a survey designed to assess hospitals' adherence to the National CLAS Standards. The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups, and cognitive interviews. Exploratory and confirmatory factor analysis of the data supported 12 composite scales: clinical cultural competency practices, human resources practices, diversity training, availability of interpreter services, interpreter services policies, quality of interpreter services, translation of written materials, leadership and strategic planning, performance management systems and quality improvement, data collection on inpatient population, data collection on service area, and community representation.
JCAHO's Hospital Accreditation Standards and Elements of Performance	JCAHO standards are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organizational functions that are essential to providing safe, high-quality care. JCAHO's state-of-the-art standards set expectations for organizational performance that are reasonable, achievable, and surveyable. JCAHO has several accreditation standards that directly or indirectly support the provision of culturally and linguistically appropriate services.
The Joint Commission 2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures	The Joint Commission categorizes its process performance measures into accountability and non-accountability measures. This approach places more emphasis on an organization's performance on accountability measures—quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement: research, proximity, accuracy, and adverse effects. Measures that meet all four criteria should be used for purposes of accountability (e.g., for accreditation, public reporting, or pay for performance). Those measures that have not been designated as accountability measures may be useful for quality improvement, exploration, and learning within individual health care organizations and are good advice in terms of appropriate patient care. The accountability measures cover areas including inpatient psychiatric services, venous thromboembolism (VTE) care, stroke care, perinatal care, immunization, tobacco treatment, and substance use.

Measure(s)	Description
Disparity-sensitive measures or CLAS-salient measures	
Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization	The measure estimates a hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) for patients discharged from the hospital with either a principal discharge diagnosis of pneumonia, including aspiration pneumonia, or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). <i>Readmission</i> is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions do not count as readmissions. CMS annually reports the measure for patients ages 65 or older who are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.
Median time to ECG	Median time from emergency department arrival to ECG (performed in the emergency department prior to transfer) for acute myocardial infarction (AMI) or chest pain patients (with probable cardiac chest pain).
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery	The measure estimates a hospital-level risk-standardized mortality rate (RSMR) for patients ages 18 and older discharged from the hospital following a qualifying isolated CABG procedure. <i>Mortality</i> is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare Fee-for-Service (FFS) patients ages 65 and older and was tested in all-payer patients ages 18 and older. An <i>index admission</i> is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome.
Risk-adjusted deep sternal wound infection	Percentage of patients ages 18 and older undergoing isolated CABG procedures who develop mediastinitis or deep sternal wound infections within 30 days postoperatively

Table 7.4. Behavioral Health Measures

Measure(s)	Description
Experience of Care and Health Outcomes (ECHO) survey	The Experience of Care and Health Outcomes (ECHO) survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions about inpatient stays or self-help groups. The survey can be used for two types of organizations that are responsible for delivering behavioral health services: managed care organizations (MCOs) and managed behavioral healthcare organizations (MBHOs).
Disparity-sensitive measures or CLAS-salient measures	
Alcohol screening and follow-up for people with serious mental illness	The percentage of patients ages 18 and older with a serious mental illness who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.
Initiation and engagement of alcohol and other drug dependence treatment	The percentage of patients ages 13 and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. <ul style="list-style-type: none"> a. Percentage of patients who initiated treatment within 14 days of the diagnosis b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Antidepressant medication management (AMM)	The percentage of patients ages 18 and older with a diagnosis of major depression and who were newly treated with antidepressant medication who remained on an antidepressant medication treatment. Two rates are reported. <ul style="list-style-type: none"> a. Effective Acute Phase Treatment: The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	This facility-level measure estimates an all-cause, unplanned, 30-day risk-standardized readmission rate (RSRR) for adult Medicare Fee-for-Service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.

Table 7.5. Public Health Measures

Measure(s)	Description
Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services (CLAS) in Local Public Health Agencies (LPHAs)	This self-assessment tool for Local Public Health Agencies (LPHAs) is aimed to offer sound measures of culturally and linguistically appropriate services. The term <i>LPHA</i> is defined as a publicly funded entity (i.e., local health department, local board of health, other local government organization) responsible for providing essential public health services within a specific jurisdiction. The instrument consists of a director or designee interview protocol, a staffing questionnaire, and a client services questionnaire. Because the content among the three survey instruments greatly overlaps, not all items from each instrument are presented in this document. In Appendix F are items from the client services questionnaire (consisting of four sections: quality monitoring and improvement, management information systems, translation and interpretation services, and other related client services and benefits) and select items from the director or designee interview protocol. See Appendix F for a list of the complete instruments, including survey questions and multiple-choice items.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey (CG-CAHPS)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Clinician/Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.
Disparity-sensitive measures or CLAS-salient measures	
Flu vaccinations for adults ages 18 and older	The percentage of adults ages 18 and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: ages 18–64 and 65 and older.
Asthma emergency department visits	The percentage of patients with asthma who have one or more visits to the emergency room for asthma during the measurement period
Depression screening, adolescents 18 years of age	The percentage of adolescents 18 years of age who had a screening for depression using a standardized tool
Preventive care and screening: tobacco use: screening and cessation intervention	The percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

Chapter Eight. Conclusions

The National CLAS Standards were developed by OMH, in collaboration with federal and nonfederal partners across the country, to provide meaningful and practical guidance to health organizations and HCOs about delivering culturally and linguistically appropriate services. The resulting 15 National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and HCOs to implement the National CLAS Standards.

OMH also recognized the importance of establishing an evaluation framework to guide long-term efforts to assess the implementation of the National CLAS Standards—to describe National CLAS Standards adoption and implementation and to examine the relationship between implementation and its associated outcomes. This report describes RAND’s approach to developing this evaluation framework. The preceding chapters provided information about the development of (1) the National CLAS Standards theory of change and setting-specific logic models, (2) evaluation questions that test the theory of change and the corresponding methods, and (3) indicators⁸ or measures and supporting data metrics to support the National CLAS Standards theory of change.

The evaluation framework, logic models, and evaluation questions and measures presented in this report are intended to provide a systematic approach for gathering data to evaluate the effectiveness of the National CLAS Standards. OMH’s intent behind supporting the development of an evaluation framework was not only to alleviate the burden on health organizations in conducting an evaluation but also to facilitate the use of similar research questions and metrics across health organizations and HCOs, which may generate more-comparable data on the importance and relevance of the National CLAS Standards in helping to address health inequities and eliminate health care disparities. As a result, we developed a companion toolkit titled *Evaluation of the National CLAS Standards: Tips and Resources* (Williams et al., forthcoming).

While this report provides details on the methodologic approach for developing key elements of the evaluation framework, the interactive toolkit is designed to support health organizations in their efforts to implement the National CLAS Standards and to improve their capacity to evaluate their approach. The toolkit focuses on translating the overall evaluation framework into elements that can be adopted by individual organizations for their own approach. Users can click on links and jump to sections that are most relevant to them based on their experience with evaluation, their health care setting, or their measurement needs. They can also read short case studies of

⁸ The terms *indicator* and *measure* can be used interchangeably. In this report, we chose to use the term *measure* to be inclusive of the wide range of types of measures, from the CAHPS measures to such disparity-sensitive clinical measures as median time to ECG.

how similar organizations have implemented and evaluated the National CLAS Standards. The toolkit is organized into four sections:

- information about the toolkit, who should use it, and what it is designed to help organizations do
- seven steps for implementing and evaluating the National CLAS Standards
- context and details relevant for evaluating specific National CLAS Standards
- an extensive list of relevant resources and information on potential data sources and metrics that may be used by organizations in conducting their evaluation.

The focus of the toolkit is on evaluation of the National CLAS Standards. Thus, it does not include extensive information on how to identify, design, or implement activities and approaches that an organization may pursue to address the National CLAS Standards. The reader is instead directed to a number of additional resources offered by HHS OMH and the Think Cultural Health website (HHS OMH, undated[b]).

As our nation grows increasingly diverse, all health organizations and HCOs will need to be poised to ensure that the care they provide is not only of high quality but is also equitable and responsive to individuals with diverse cultural experiences, beliefs, and preferences and with a wide range of language and literacy skills. The National CLAS Standards call attention to 15 areas that, if addressed, hold great promise for helping health organizations and HCOs address current barriers to providing equitable care. The evaluation framework outlined in this report and in the companion toolkit is intended to support health organizations in their efforts. By providing a conceptual framework, logic models, research questions, and measures that are widely collected, health organizations can assess the impact of their efforts more easily, both on the individuals they serve and on their organizations. Such evaluations provide valuable data and insights that inform CQI efforts within a given health organization and collectively can inform and help to shape systems-level change to provide culturally and linguistically appropriate care and services.

Appendix A. List of Technical Advisory Group Members

- Margo L. Bailey, Ph.D., M.P.A., HHS Office of the Assistant Secretary for Planning and Evaluation
- Helen Burstin, M.D., M.P.H., FACP, chief scientific officer, the National Quality Forum
- Carolyn W. Caldwell, M.S., FACHE, CEO and president, Desert Regional Medical Center
- J. Emilio Carrillo, M.D., M.P.H., vice president, Community Health, New York-Presbyterian Hospital
- Tawara D. Goode, M.A., assistant professor and director, Georgetown University National Center for Cultural Competence and Center for Child and Human Development
- LaMar Hasbrouck, M.D., M.P.H., executive director, National Association of County and City Health Officials
- Cara James, Ph.D., director, Office of Minority Health, CMS
- Rodrigo Monterrey, acting director, Massachusetts Department of Public Health, Office of Health Equity
- Roslyn Holliday Moore, M.S., senior policy analyst, Office of Behavioral Health Equity, Substance Abuse and Mental Health Services Administration
- Gayle Tang, M.S.N., R.N., adjunct professor and health equity consultant
- Alec Thundercloud, M.D., director, Office of Clinical and Preventive Services, Indian Health Service.

Appendix B. Cross-Cutting Measures

When we developed the process and outcomes/impact measures described in Chapter Seven, we classified those measures that are relevant to more than one setting as *cross-cutting*. In Table B.1, we list the six cross-cutting measures identified, along with a brief description, area of focus, source, the settings in which the measure is applicable, and the reference for each measure. Table B.2 provides additional detail for each measure and lists the items that comprise each measure.

Table B.1. Cross-Cutting Measures

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey (CG-CAHPS) that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of their provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.	Cultural competency	National Quality Forum (NQF) #1904—Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set (AHRQ)	Applicable to ambulatory care, hospital, and behavioral health settings. See Table B.2 for list of measures.	NQF #1904 Measure Specifications (NQF, 2012c) Endorsement Summary – Healthcare Disparities and Cultural Competency Measures (NQF, 2012f)
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician/Group Survey (CG-CAHPS). The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.	Health literacy	NQF #1902—Clinician/groups' health literacy practices based on the CAHPS Item Set for Addressing Health Literacy (AHRQ)	Applicable to ambulatory care, hospital, and behavioral health settings. See Table B.2 for list of measures.	NQF #1902 Measure Specifications (NQF, 2012d) Endorsement Summary – Healthcare Disparities and Cultural Competency Measures (NQF, 2012f)
Patients receiving language services supported by qualified language services providers	This measure is used to assess the percentage of patients with limited English proficiency (LEP) receiving both initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees	Language services	NQF #1821—L2: Patients receiving language services supported by qualified language services providers (measure steward: George Washington University)	Applicable to all settings.	NQF #1821 L2 Measure Specifications (NQF, 2012b) NQF, 2012f

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Screening for preferred spoken language for health care	<p>during critical times in a patient's health care experience.</p> <p>This measure is used to assess the percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.</p>	Language screening	<p>Department of Health Policy)</p> <p>NQF #1824—L1A: Screening for preferred spoken language for health care (measure steward: George Washington University Department of Health Policy)</p>	<p>Applicable to ambulatory care, hospital, and behavioral health settings.</p>	<p>NQF 1824-L1A Measure Specifications (NQF, 2012a)</p> <p>Endorsement Summary – Healthcare Disparities and Cultural Competency Measures (NQF, 2012f)</p>
Cultural Competency Implementation Measure	The Cultural Competency Implementation Measure is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey. Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.	Cultural competency implementation	NQF #1919—Cultural Competency Implementation Measure (measure steward: RAND Corporation)	<p>Applicable to ambulatory care, hospital, and behavioral health settings.</p> <p>See Table B.2 for list of measures. These measures have yet to be tested/validated.</p>	<p>NQF #1919 Measure Specifications (NQF, 2012e)</p> <p>Endorsement Summary – Healthcare Disparities and Cultural Competency Measures (NQF, 2012f)</p>
Communication Climate Assessment Toolkit (C-CAT)	<p>C-CAT, which has been extensively validated in diverse health care organizations nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices.</p> <p>When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment, conduct</p>	Communication climate	C-CAT survey (measure steward: University of Colorado Center for Bioethics and Humanities)	Applicable to all settings. See Table B.2 for list of measures.	<p>C-CAT Surveys (Center for Bioethics and Humanities, undated)</p> <p>Endorsement Summary – Healthcare Disparities and Cultural Competency Measures</p>

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
	<p>statistical analysis of data (including comparisons against a national benchmarking database), and create a feedback report featuring personalized, site-specific recommendations.</p> <p>In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it complements CAHPS assessments, documents compliance with Title VI culturally and linguistically appropriate services standards, and is invaluable in meeting The Joint Commission's patient-centered communication standards.</p>				(NQF, 2012f)

Table B.2. Cross-Cutting Measures: Additional Details

Measures	Items
<p>Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set</p> <p>(MEASURES BELOW: 5 item sets, 2 composite measures)</p> <p>Patient-provider communication</p> <p>(Note: CU3, CU5, and CU8 form a composite measure: Providers are polite and considerate)</p> <p>Complementary and alternative medicine</p>	<p>These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey (CG-CAHPS) that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of their provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.</p> <p>CU1: In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English?</p> <p>CU2: In the last 12 months, how often did this provider use medical words you did not understand?</p> <p>CU3: In the last 12 months, how often did this provider talk too fast when talking with you?</p> <p>CU4: In the last 12 months, how often did this provider ignore what you told him or her?</p> <p>CU5: In the last 12 months, how often did this provider interrupt you when you were talking?</p> <p>CU6: In the last 12 months, how often did this provider show interest in your questions and concerns?</p> <p>CU7: In the last 12 months, how often did this provider answer all of your questions to your satisfaction?</p> <p>CU8: In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?</p> <p>CU9: People sometimes see someone else besides their providers or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist?</p> <p>CU10: In the last 12 months, have you ever used an herbalist?</p> <p>CU11: In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy?</p> <p>CU12: Some people use natural herbs for health reasons or to stay healthy. Natural herbs include such things as ginseng,</p>

Measures	Items
	green tea, and other herbs. People can take them as a pill, a tea, an oil, or a powder. In the last 12 months, have you ever used natural herbs for your own health? CU13: In the last 12 months, has this provider ever asked you if you used natural herbs?
Experiences of discrimination due to race/ethnicity, insurance, or language	CU14: In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? CU15: In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you do not have health insurance?
Experiences leading to trust or distrust, including level of trust, caring, and truth-telling	CU16: In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? CU17: In the last 12 months, did you feel you could trust this provider with your medical care? CU18: In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news?
(Note: CU16–CU20 form a composite measure: Providers are caring and inspire trust)	CU19: In the last 12 months, did you feel this provider cared as much as you do about your health? CU20: In the last 12 months, did you feel this provider really cared about you as a person? CU21: Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?
Linguistic competency (Access to language services)	CU22: What is your preferred language? CU23: How well do you speak English? CU24: In the last 12 months, how often were you treated unfairly at this provider's office because you did not speak English very well? CU25: An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the provider's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this provider's office? CU26: In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? CU27: In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider? CU28: In the last 12 months, when you used an interpreter provided by this office, who was the interpreter you used most often? CU29: In the last 12 months, how often did this interpreter treat you with courtesy and respect? CU30: Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? CU31: In the last 12 months, did any of your appointments with this provider start late? CU32: Did any of your appointments start late because you had to wait for an interpreter? CU33: In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this provider? CU34: In the last 12 months, did you use friends or family members as interpreters because that was what you preferred?
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician/Group Survey (CG-CAHPS). The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year.

Measures	Items
(MEASURES BELOW: 5 item sets, 1 composite measure)	Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Communication with provider	<p>HL1: In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? (Never)</p> <p>HL2: In the last 12 months, how often did this provider use medical words you did not understand? (Never)</p> <p>HL3: In the last 12 months, how often did this provider talk too fast when talking with you? (Always)</p> <p>HL4: In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? (Always)</p> <p>HL5: In the last 12 months, how often did this provider ignore what you told him or her? (Never)</p> <p>HL6: In the last 12 months, how often did this provider interrupt you when you were talking? (Never)</p> <p>HL7: In the last 12 months, how often did this provider show interest in your questions and concerns? (Always)</p> <p>HL8: In the last 12 months, how often did this provider answer all of your questions to your satisfaction? (Always)</p> <p>HL9: In the last 12 months, how often did this provider give you all the information you wanted about your health? (Always)</p> <p>HL10: In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? (Always)</p> <p>HL17: In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you? (Never)</p>
Disease self-management	<p>HL11: In the last 12 months, did you see this provider for a specific illness or for any health condition? [screener for HL12–17] (NA)</p> <p>HL12: In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition? (Yes)</p> <p>HL13: In the last 12 months, how often were these instructions easy to understand? (Always)</p> <p>HL14: In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? (Always)</p> <p>HL15: Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you needed to do to take care of this illness or health condition? (Always)</p> <p>HL16: In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back? (Always)</p>
Communication about medicines	<p>HL19: In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? [screener for HL19–25] (NA)</p> <p>HL20: In the last 12 months, did this provider give instructions about how to take your medicines? (Yes)</p> <p>HL21: In the last 12 months, how often were these instructions about how to take your medicines easy to understand? (Always)</p> <p>HL22: In the last 12 months, did this provider explain the possible side effects of your medicines? (Yes)</p> <p>HL23: In the last 12 months, how often were these explanations easy to understand? (Always)</p> <p>HL24: In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines? (Yes)</p> <p>HL25: In the last 12 months, how often was the written information you were given easy to understand? (Always)</p> <p>HL26: In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines? (Always)</p>

(Note: HL20, HL22, HL24, and HL26 form a composite measure: Providers communicate about medicines)

Measures	Items
Communication about test results	Core 21: In the last 12 months, did this provider order a blood test, X-ray, or other test for you? [screener for Core 22] (NA) Core 22: In the last 12 months, when this provider ordered a blood test, X-ray, or other test for you, how often did someone from this provider's office follow up to give you those results? (NA) [screener for HL26] HL26: In the last 12 months, how often were the results of your blood test, X-ray, or other test easy to understand? (Always)
Communication about forms	HL27: In the last 12 months, did you sign any forms at this provider's office? [screener for HL28] (NA) HL28: In the last 12 months, how often did someone explain the purpose of a form before you signed it? (Always) HL29: In the last 12 months, did you fill out any forms at this provider's office? [screener for HL30–31] (NA) HL30: In the last 12 months, how often were you offered help to fill out a form at this provider's office? (Always) HL31: In the last 12 months, how often were the forms from this provider's office easy to fill out? (Always)
Cultural Competency Implementation Measure (MEASURES BELOW: 12 subdomains)	The Cultural Competency Implementation Measure is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey. The target audience for this survey includes health care organizations across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for quality improvement, to provide information that can help health care organizations establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting. Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.
Cultural Competency Implementation Measure— Subdomain: Commitment to Serving a Diverse Population	Has your organization: <ol style="list-style-type: none"> 1. reviewed its vision statement, goals, and mission to ensure that they reflect a commitment to culturally competent care? 2. provided staff members with the opportunity to provide input and comment on the action plan for providing culturally competent care? 3. made the vision statement, goals, mission, and the action plan for providing culturally competent care publicly available throughout the organization and the community? 4. developed and/or revised the organization's vision statement, goals, and mission to ensure that it reflects a commitment to providing high-quality, culturally competent care for diverse populations? 5. developed an action plan that includes explicit expectations and measurable objectives relating to culturally competent care? 6. implemented or updated the action plan for providing high-quality, culturally competent care to the diverse populations your organization serves?
Cultural Competency Implementation Measure— Subdomain: Leadership Diversity	Has your organization: <ol style="list-style-type: none"> 1. reviewed the strategies for staff recruitment and the selection processes to assess whether staff at all levels of the organization reflect the demographic characteristics of the service area? 2. ensured that staff recruitment and selection processes focus on meeting the needs of the organization's goals for culturally competent care? 3. sought input from community leaders on strategies to recruit, retain, and promote staff at all levels of the organization (including upper management) from the community? 4. used a committee of current diverse staff to develop strategies for recruitment, retention, and promotion of staff that

Measures	Items
	<p>reflect the community at all levels of the organization (including upper management)?</p> <ol style="list-style-type: none"> conducted an internal assessment on how to address the need for staff diversity at all levels of the organization, including upper management? conducted an external assessment on how to address the need for staff diversity at all levels of the organization, including upper management? (This can include obtaining data on the demographic characteristics of the service area and comparing it to the diversity of staff.) developed or implemented strategies for recruiting, retaining, and promoting a diverse staff at all levels of the organization, including upper management? advertised and recruited from the community served?
Cultural Competency Implementation Measure— Subdomain: Dedicated Staff and Resources	<p>Have your organization's leaders:</p> <ol style="list-style-type: none"> consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed fiscal resources to appropriately meet the cultural needs of patients? consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed human resources to appropriately meet the cultural needs of patients? documented where the fiscal support for culturally competent policies and practices is within the organization? established and enforced organizational policies that support the allocation of fiscal resources for cultural competency? ensured that there are budget line items and specific allocations for cultural competency activities and programs that reflect the organization's goals for providing culturally competent care? provided staff with time and resources for training programs and practices that promote culturally competent care? (Check all that apply) provided training and coaching on culturally competent care to new staff? provided continued training and coaching on culturally competent care to current staff?
Cultural Competency Implementation Measure— Subdomain: Strategic Planning	<p>Has your organization:</p> <ol style="list-style-type: none"> reviewed the organizational strategic plan to ensure that it has clear goals that include providing culturally competent services? involved consumers and the community served in the development of a strategic plan that has clear goals that include providing culturally competent services? involved staff in the development of a strategic plan that has clear goals that include providing culturally competent services? gathered data on community needs to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? conducted an organizational self-assessment to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? used results from the community needs assessment and self-assessment processes to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan?
Cultural Competency Implementation Measure— Subdomain: Reward Systems	<p>Has your organization:</p> <ol style="list-style-type: none"> reviewed job performance evaluation criteria to assess staff to ensure that they include specific improvement goals related to cultural competence? reviewed evaluation criteria used to assess initiatives and programs within the organization that promote cultural

Measures	Items
	<p>competence?</p> <ol style="list-style-type: none"> 3. compared job performance evaluation criteria that include aspects of cultural competence with other recognition activities and awards to make sure they are on equal par? 4. compared evaluation criteria to assess initiatives and programs that promote cultural competence with other recognition activities and awards to make sure they are on equal par? 5. established standardized evaluation criteria that include aspects of cultural competence to assess individuals within the organization who promote cultural competency? 6. established standardized evaluation criteria that include aspects of cultural competence to assess initiatives and programs within the organization that promote cultural competency? 7. rewarded or recognized individuals within the organization who improve cultural competency and reduce health care disparities or who go beyond the preferred practices included in the <i>Framework and Preferred Practices for Measuring and Reporting on Cultural Competency</i>? 8. rewarded or recognized initiatives or programs within the organization that improve cultural competency and reduce health care disparities or that go beyond the preferred practices included in the <i>Framework and Preferred Practices for Measuring and Reporting on Cultural Competency</i>?
<p>Cultural Competency Implementation Measure— Subdomain: Language Access</p>	<p>Has your organization:</p> <ol style="list-style-type: none"> 1. reviewed its language assistance resource policies to ensure that your organization is providing language assistance to LEP persons at no cost to them? 2. reviewed language assistance services available in different areas of the organization? 3. reviewed wait times for language assistance services available in different areas of the organization? 4. evaluated the qualifications of all staff providing interpreting services or care directly provided in another language to patients? 5. assessed the competency of all staff providing interpreting services or care directly provided in another language to patients? 6. monitored all staff providing interpreting services or care directly provided in another language to patients to determine competency to provide services in health care settings? 7. created uniform procedures for timely and effective telephone communication between staff and LEP patients? 8. informed LEP individuals—in their primary language—that they have the right to free language assistance services and that such services are readily available? 9. distributed, at points of contact, written notices with information informing patients that they have the right to free language assistance services and that such services are readily available? 10. used language identification or “I speak. . .” cards to inform patients that they have the right to free language assistance services and that such services are readily available? 11. posted translated signage at points of entry in regularly encountered languages that language assistance services are available free of charge? 12. distributed to the public brochures, booklets, outreach materials, and other materials in regularly encountered non-English languages that include statements about the language assistance services available and the right to free language assistance services? 13. provided qualified language resources, including competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters? 14. provided bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments,

Measures	Items
	assist with transfers within a facility)?
Cultural Competency Implementation Measure— Subdomain: Clinical Encounter	<p>Within the past 12 months, how often has your organization:</p> <ul style="list-style-type: none"> reviewed patient care plans provided to patients to ensure that they address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? <p>Within the past 12 months, has your organization:</p> <ul style="list-style-type: none"> developed a comprehensive care plan with patients and their caregivers to ensure that the plan addresses the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? <p>Within the past 12 months, how often has your organization:</p> <ul style="list-style-type: none"> collected information on patients' and families' primary written and spoken languages and any cultural beliefs that might affect the care plan, including but not limited to those involving spirituality/religion, nation of origin, and ethnicity? <p>Within the past 12 months, has your organization:</p> <ul style="list-style-type: none"> implemented comprehensive care plans that address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system?
Cultural Competency Implementation Measure— Subdomain: Training Commitment and Content	<p>Has your organization:</p> <ol style="list-style-type: none"> reviewed training materials and programs used to provide cultural competence training? assessed the organization's progress in recruiting, hiring, and retaining qualified, diverse staff at all levels of the organization? evaluated cultural competence training programs to ensure that managers and staff at all levels of the organization receive training that is effective, relevant, and up to date? had human resource managers assess the qualifications and competency of staff responsible for cultural competency training? had human resource managers assess and report on employee promotions, terminations, and resignations to evaluate how well the organization is doing in the promotion and retention of a diverse workforce? developed or updated training materials or programs to increase staff awareness of the cultural needs, beliefs, and attitudes of the predominant populations served by the organization? included or updated training materials or programs to provide staff with in-depth information about the causes of and research on cultural competency, inequities, and health care disparities? provided staff with time and resources for training programs and practices that promote culturally competent care? (Check all that apply) provided training and coaching to new staff to increase cultural competency awareness, knowledge, and skills? (Check all that apply) provided training and coaching to current staff to increase cultural competency awareness, knowledge, and skills? (Check all that apply)
Cultural Competency Implementation Measure— Subdomain: Community Outreach	<p>Has your organization:</p> <ol style="list-style-type: none"> identified resources in the community to develop training programs, research projects, and outreach activities to help understand and address the cultural needs of the communities served? created a community advisory board that is representative of the diverse community served by the organization? established or maintained collaborative relationships with community organizations to help understand and address the cultural needs of the communities served? worked with community organizations on specific health education programs to raise awareness about local health care services?

Measures	Items
Cultural Competency Implementation Measure— Subdomain: Collection of Patient Cultural Competency-Related Information	<p>5. utilized community experience and resources to develop training programs, research projects, or outreach activities to address the needs of culturally diverse populations, or to address health care disparities and equity in the community?</p> <p>Has your organization:</p> <ol style="list-style-type: none"> 1. reviewed patient data on race/ethnicity to ensure that you are collecting this information using OMB categories as modified by HRET231? 2. reviewed data from health records to ensure that data on an individual patient's race and ethnicity and primary written and spoken language are collected? 3. reviewed data from your organization's management information system to ensure that data from patients' health records on an individual patient's race and ethnicity and primary written and spoken language are integrated into the management information systems? 4. reviewed policies and procedures to ensure that patients' race/ethnicity data is not used for discriminatory purposes? 5. developed, maintained, or improved the process for collecting data on an individual patient's race and ethnicity and primary written and spoken language in the patient's health record? 6. developed, maintained, or improved the process for integrating data on an individual patient's race and ethnicity and primary written and spoken language into management information systems? 7. updated information on patients' race and ethnicity and primary written and spoken language in the last 12 months?
Cultural Competency Implementation Measure— Subdomain: Quality Improvement	<p>Has your organization:</p> <ol style="list-style-type: none"> 1. identified NQF-endorsed performance measures to collect and use for quality improvement activities focused on providing more culturally competent care and discovering and eliminating health care disparities in access, outcomes, or patient experiences with care? 2. based on national benchmarks, set organizational targets and benchmarks for performance measures? 3. utilized performance improvement methodology and science, such as rapid-cycle change and Plan-Do-Study-Act cycles, to implement quality improvement activities focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? 4. used information on patients' race, ethnicity, and primary written and spoken language to design and/or inform quality improvement strategies and projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? 5. implemented quality improvement strategies or projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care?
Cultural Competency Implementation Measure— Subdomain: Assessment of Patient Experiences with Care	<p>Within the past 12 months, has your organization:</p> <ol style="list-style-type: none"> 1. collected information on model health care programs that use patient- and family-centered communication? 2. conducted site visits to successful health care programs that use patient- and family-centered communication? 3. consulted published guides on improving patient-provider communication? 4. utilized focus groups or patient surveys in the patient's preferred language to collect data on patient experience of care as it relates to patient-provider communication? 5. collected data or sought input from staff on patient and family communication needs and performance? 6. utilized a patient survey to collect patient experience of care data that is being publicly reported either by your organization or by another organization? 7. designed communication initiatives based on the needs of patients, families, and staff? 8. used champions to build support for new communication initiatives by presenting qualitative and quantitative data on patient and family communication needs and staff performance?

Measures	Items
Communication Climate Assessment Toolkit (C-CAT)	<p>9. implemented communication initiatives designed to improve patient and family-centered communication?</p> <p>10. utilized findings from patient focus groups or patient surveys to assess whether patients and their families find that patient-provider communication is effective?</p> <p>C-CAT, which has been extensively validated in diverse health care organizations nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices. When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment; conduct statistical analysis of data (including comparisons against a national benchmarking database); and create a feedback report featuring personalized, site-specific recommendations. In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it complements CAHPS assessments, documents compliance with Title VI culturally and linguistically appropriate services standards, and is invaluable in meeting The Joint Commission's patient-centered communication standards.</p>
(MEASURES BELOW: 7 measures using items across 5 different surveys: staff, patient, pediatric patient, executive, and organizational)	
Workforce development measure derived from the workforce development domain of the C-CAT	Site score on the measure domain of "workforce development" of the C-CAT, 0–100
Leadership commitment measure derived from the leadership commitment domain of the C-CAT	Site score on the measure derived from the domain of "leadership commitment" of the C-CAT, 0–100
Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT	Site score for "cross-cultural communication" domain of the C-CAT, 0–100
Health literacy measure derived from the health literacy domain of the C-CAT	Site score on the domain of "health literacy" of the C-CAT, 0–100
Performance evaluation measure derived from the performance evaluation domain of the C-CAT	Site score on domain of "performance evaluation" of the C-CAT, 0–100
Individual engagement measure derived from the individual engagement	Site score on "individuals' engagement" domain of patient-centered communication, per the C-CAT, 0–100

Measures	Items
domain of the C-CAT	
Language services measure derived from the language services domain of the C-CAT	Site score on the domain of “language services” of the C-CAT, 0–100

Appendix C. Ambulatory Care Measures

In developing the process and outcomes/impact measures described in Chapter Seven, we identified measures relevant to the ambulatory care setting. In Table C.1, we list examples of ambulatory care measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that an ambulatory care organization might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table C.2 provides additional detail for each measure and summarizes the relevant items that comprise each measure.

Table C.1. Ambulatory Care Measures

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Set	<p>Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Cultural Competence Item Set, a supplement to the CAHPS survey, is designed to capture the patient's perspective on the cultural competence of health care providers. The Cultural Competence Item Set covers the following topics: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; and linguistic competency (access to language services).</p> <p>In Weech-Maldonado et al. (2012b), measures are grouped into eight composites: doctor communication—positive behaviors; doctor communication—negative behaviors; trust; access to interpreter services; doctor communication—health promotion; doctor communication—alternative medicine; shared decisionmaking; and equitable treatment</p>	Cultural competency	CAHPS Cultural Competence Item Set	See Table C.2 for list of measures.	<p>CAHPS Cultural Competence Set (AHRQ, 2012)</p> <p>Weech-Maldonado et al., 2012b</p>

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Consumer Assessment of Healthcare Providers and Systems Clinician/Group Survey (CG-CAHPS)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.	Patient experience	CAHPS Clinician/Group Survey (CG-CAHPS)	See Table C.2 for list of measures.	CAHPS Clinician/Group Survey (AHRQ, 2013b)
Disparity-Sensitive Measures or CLAS-Salient Measures					
Controlling high blood pressure	The percentage of patients ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.	Prevention and treatment, effective clinical care	NQF #18 (measure steward: National Committee of Quality Assurance [NCQA])	BP < 150/90 in patients ages 60 and older without diabetes considered controlled in HEDIS. This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: "18") (NQF, undated) Healthcare Disparities and Cultural Competency Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Diabetes: hemoglobin A1c poor control	The percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	Effective communication and care coordination	NQF #59, #575 (measure steward: NCQA)	HbA1c < 8% also valid measure given improvements in control.	NQF Quality Positioning System Measure Specifications (search: "59" or "575")

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
				This is a disparity-sensitive measure.	(NQF, undated) Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Uncontrolled diabetes admission rate	Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population, ages 18 and older. Excludes obstetric admissions and transfers from other institutions.	Patient safety, primary prevention	NQF #638 (measure steward: Agency for Healthcare Research and Quality [AHRQ])	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: "638") (NQF, undated) Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 and older. Excludes obstetric admissions and transfers from other institutions.	Patient safety, primary prevention	NQF #272 (measure steward: AHRQ)	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: "272") (NQF, undated) Healthcare Disparities and Cultural

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
					Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)

Table C.2. Ambulatory Care Measures: Additional Details

Measures	Items
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence Set (MEASURES BELOW: 8 composites)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Cultural Competence Item Set, a supplement to the CAHPS survey, is designed to capture the patient's perspective on the cultural competence of health care providers. The Cultural Competence Item Set covers the following topics: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; linguistic competency (access to language services). In Weech-Maldonado et al. (2012b), measures are grouped into eight composites: doctor communication—positive behaviors; doctor communication—negative behaviors; trust; access to interpreter services; doctor communication—health promotion; doctor communication—alternative medicine; shared decision-making; and equitable treatment.
Doctor communication—positive behaviors	In the last 12 months, how often did this doctor explain things in a way that was easy to understand? In the last 12 months, how often did this doctor listen carefully to you? In the last 12 months, how often did this doctor spend enough time with you? In the last 12 months, how often did this doctor show respect for what you had to say? In the last 12 months, how often did this doctor give you easy-to-understand instructions about taking care of these health problems or concerns?
Doctor communication—negative behaviors	In the last 12 months, how often did this doctor interrupt you when you were talking? In the last 12 months, how often did this doctor speak too fast when talking with you? In the last 12 months, did this doctor ever use a condescending, sarcastic, or rude tone or manner with you?
Trust	Do you feel you can tell this doctor anything, even things that you might not tell anyone else? Do you trust this doctor with your medical care? Do you feel this doctor always tells you the truth about your health, even if there is bad news? Do you feel this doctor cares as much as you do about your health? In the last 12 months, how often did you feel this doctor really cared about you as a person?
Access to interpreter services	In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor's office? In the last 12 months, how often did your visit with this doctor start late because you had to wait for an interpreter? Do not

Measures	Items
	include friends or family members. In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor's office? Do not include friends or family members.
Doctor communication— health promotion	In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits? In the last 12 months, did you and this doctor talk about the exercise or physical activity you get? In the last 12 months, did you and this doctor talk about things in your life that worry you or cause you stress? In the last 12 months, did this doctor ever ask you whether there was a period of time when you felt sad, empty, or depressed?
Doctor communication— alternative medicine	In the last 12 months, has this doctor ever asked you whether you have used these other people to help with an illness or to stay healthy (e.g., acupuncturist or herbalist)? In the last 12 months, has this doctor ever asked you whether you used natural herbs?
Shared decision-making	In the last 12 months, did this doctor talk with you about the pros and cons of each choice for your treatment or health care? In the last 12 months, when there was more than one choice for your treatment or health care, did this doctor ask which choice you thought was best for you?
Equitable treatment	In the last 12 months, how often have you been treated unfairly at this doctor's office because of your race or ethnicity? In the last 12 months, how often have you been treated unfairly at this doctor's office because of the type of health insurance you have or because you do not have health insurance?
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey (SELECTED MEASURES BELOW)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Clinician/Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.
Getting timely appointments, care, and information	Patient got an appointment for urgent care as soon as needed. Patient got an appointment for non-urgent care as soon as needed. Patient got an answer to medical question the same day he/she contacted provider's office.
Providers' use of information to coordinate patient care	Provider knew important information about the patient's medical history. Someone from the provider's office followed up with the patient to give results of blood test, X-ray, or other test. Someone from the provider's office talked about all prescription medications being taken.

Appendix D. Hospital Measures

In developing the process and outcomes/impact measures described in Chapter Seven, we identified measures relevant to the hospital setting. In Table D.1, we list examples of hospital measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that a hospital might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table D.2 provides additional detail for each measure and summarizes the relevant items that comprise each measure.

Table D.1. Hospital Measures

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS Hospital Survey or Hospital CAHPS, is a standardized survey instrument and data-collection methodology to measure patients' perspectives of hospital care. The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.	Cultural competency	HCAHPS	See Table D.2 for list of measures.	HCAHPS Survey (AHRQ, 2014)
HCAHPS Survey Health Literacy Set	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Hospital Survey (HCAHPS). The item set includes the following domains: information about medications, communication between nurses and patients, communication between doctors and patients, communication about tests, communication about forms, and information about how to care for yourself at home.	Health literacy	HCAHPS Health Literacy	See Table D.2 for list of measures.	HCAHPS Health Literacy Item Set (AHRQ, 2012)

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Cultural Competency Assessment Tool for Hospitals (CCATH)	The Cultural Competency Assessment Tool for Hospitals (CCATH) is a survey designed to assess hospitals' adherence to the National CLAS Standards. The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups, and cognitive interviews. Exploratory and confirmatory factor analysis of the data supported 12 composite scales: clinical cultural competency practices, human resources practices, diversity training, availability of interpreter services, interpreter services policies, quality of interpreter services, translation of written materials, leadership and strategic planning, performance management systems and quality improvement, data collection on inpatient population, data collection on service area, and community representation.	Cultural competency	CCATH	See Table D.2 for list of measures.	CCATH Overview (Institute for Diversity and Health Equity, undated.)
The Joint Commission Hospital Accreditation Standards and Elements of Performance	Joint Commission standards are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high-quality care. The Joint Commission's state-of-the-art standards set expectations for organizational performance that are reasonable, achievable, and surveyable. The Joint Commission has several accreditation standards that directly or indirectly support the provision of culturally and linguistically appropriate services.	Culturally and linguistically appropriate services	JCAHO Accreditation Standards	See Table D.2 for list of measures.	A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Joint Commission Hospital Accreditation Standards (The Joint Commission, 2014)
The Joint Commission: 2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures	The Joint Commission categorizes its process performance measures into accountability and non-accountability measures. This approach places more emphasis on an organization's performance on <i>accountability measures</i> —quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement:	Accountability	JCAHO Accountability Measures	See Table D.2 for list of measures.	2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures (The Joint Commission,

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
	research, proximity, accuracy, and adverse effects. Measures that meet all four criteria should be used for purposes of accountability (e.g., for accreditation, public reporting, or pay for performance). Those measures that have not been designated as accountability measures may be useful for quality improvement, exploration, and learning within individual health care organizations and are good advice in terms of appropriate patient care. The accountability measures cover areas including inpatient psychiatric services, venous thromboembolism (VTE) care, stroke care, perinatal care, immunization, tobacco treatment, and substance use.				2016)
Disparity-Sensitive Measures or CLAS-Salient Measures					
Hospital 30-day, all-cause risk-standardized readmission rate (RSRR) following pneumonia hospitalization	The measure estimates a hospital-level 30-day, all-cause risk-standardized readmission rate (RSRR) for patients discharged from the hospital with either a principal discharge diagnosis of pneumonia, including aspiration pneumonia, or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). <i>Readmission</i> is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions do not count as readmissions. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare hospitalized in non-federal hospitals.	Patient safety, care coordination	NQF #506, #505, #695, #1891, #2515, #1551 (measure steward: Centers for Medicare & Medicaid Services)	Also available for AMI, PCI, COPD, HF, CABG, THA/TKA This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: "506," "505," "695," "1891," "2515," or "1551") (NQF, undated) Commissioned Paper: Healthcare Disparities Measurement (Weissman et al., 2012)
Median time to ECG	Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or chest pain patients (with probable cardiac chest pain).	Prevention and treatment	NQF #289 (measure steward: Centers for Medicare & Medicaid)		NQF Quality Positioning System Measure Specifications (search: "289") (NQF, undated)

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery	The measure estimates a hospital-level risk-standardized mortality rate (RSMR) for patients ages 18 and older discharged from the hospital following a qualifying isolated CABG procedure. <i>Mortality</i> is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare Fee-for-Service (FFS) patients ages 65 and older and was tested in all-payer patients ages 18 years and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome.	Patient safety, care coordination	Services) NQF #2558, #230, #1893, #229, #468 (measure steward: Centers for Medicare & Medicaid Services)	Also available for AMI, COPD, HF, pneumonia This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: “2558,” “230,” “1893,” “229,” or “468”) (NQF, undated) Commissioned Paper: Healthcare Disparities Measurement (Weissman et al., 2012)
Risk-adjusted deep sternal wound infection	Percentage of patients ages 18 and older undergoing isolated CABG who develop mediastinitis or deep sternal wound infection within 30 days postoperatively	Prevention and treatment, safety	NQF #130 (measure steward: Society of Thoracic Surgeons)	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: “130”) (NQF, undated) Commissioned Paper: Healthcare Disparities Measurement (Weissman et al., 2012)

NOTE: PCI = percutaneous coronary intervention. COPD = chronic obstructive pulmonary disease. HF = heart failure. THA/TKA = total hip arthroplasty/total knee arthroplasty.

Table D.2. Hospital Measures: Additional Details

Measures	Items
<p>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey</p> <p>(SELECTED MEASURES BELOW)</p>	<p>The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology to measure patients' perspectives of hospital care.</p> <p>The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.</p>
Nurse communication	<p>During this hospital stay, how often did nurses treat you with courtesy and respect?</p> <p>During this hospital stay, how often did nurses listen carefully to you?</p> <p>During this hospital stay, how often did nurses explain things in a way you could understand?</p>
Doctor communication	<p>During this hospital stay, how often did doctors treat you with courtesy and respect?</p> <p>During this hospital stay, how often did doctors listen carefully to you?</p> <p>During this hospital stay, how often did doctors explain things in a way you could understand?</p>
Communication about medicines	<p>Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?</p> <p>Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?</p>
Discharge information	<p>After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?</p> <p>During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?</p> <p>During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?</p>
Care transition	<p>During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.</p> <p>When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</p> <p>When I left the hospital, I clearly understood the purpose for taking each of my medications.</p>
<p>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Health Literacy Set</p> <p>(MEASURES BELOW: 6 item sets, 2 composite measures)</p>	<p>These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Hospital Survey (HCAHPS). The item set includes the following domains: information about medications, communication between nurses and patients, communication between doctors and patients, communication about tests, communication about forms, and information about how to care for yourself at home.</p>
Information about medications	<p>H-HL1: Staff asked patient to describe how patient would take medications at home.</p> <p>H-HL2: Staff told patient who to call if patient had questions about medications.</p>
Communication between nurses and patients	<p>H-HL3: Nurses were hard to understand because of the way they spoke patient's language.</p> <p>H-HL4: Nurses used medical words patient did not understand.</p>

Measures	Items
	<p>H-HL5: Nurses spoke too fast.</p> <p>H-HL6: Nurses interrupted patient.</p> <p>H-HL7: Nurses answered all questions to patient's satisfaction.</p> <p>H-HL8: Nurses used condescending, sarcastic, or rude tone or manner with patient.</p> <p>H-HL9: Nurses cared about patient as a person.</p>
Communication between doctors and patients	<p>H-HL10: Doctors were hard to understand because of the way they spoke patient's language.</p> <p>H-HL11: Doctors used medical words patient did not understand.</p> <p>H-HL12: Doctors spoke too fast.</p> <p>H-HL13: Doctors used pictures, drawings, models, or videos to explain things.</p> <p>H-HL14: Doctors interrupted patient.</p> <p>H-HL15: Doctors answered all questions to patient's satisfaction.</p> <p>H-HL16: Doctors made sure patient understood all information.</p> <p>H-HL17: Doctors used condescending, sarcastic, or rude tone or manner with patient.</p> <p>H-HL18: Doctors cared about patient as a person.</p>
<p>Communication about tests</p> <p>(Note: H-HL20 through H-HL23 form a composite measure: how well hospital staff explain tests and test results)</p>	<p>H-HL19: Patient had a blood test, X-ray, or other test.</p> <p>H-HL20: Hospital staff explained what a blood test, X-ray, or other test was for.</p> <p>H-HL21: Explanation of blood test, X-ray, or other test was easy to understand.</p> <p>H-HL22: Hospital staff explained blood test, X-ray, or other test results to patient.</p> <p>H-HL23: Blood test, X-ray, or other test results were easy to understand.</p>
<p>Communication about forms</p> <p>(Note: H-HL25, H-HL27, H-HL28, and H-HL29 form a composite measure: ease of filling out forms)</p>	<p>H-HL24: Patient had to sign forms.</p> <p>H-HL25: Staff explained the purpose of a form before patient signed it.</p> <p>H-HL26: Patient had to fill out forms.</p> <p>H-HL27: Staff offered patient help in filling out a form.</p> <p>H-HL28: Forms were easy for patient to fill out.</p> <p>H-HL29: Patient was given enough time to fill out forms.</p> <p>H-HL30: Patient needed forms in a language other than English.</p> <p>H-HL31: Forms were available in patient's language.</p>
Information about how to care for yourself at home	<p>H-HL32: Patient went to own home, someone else's home, or another health facility.</p> <p>H-HL33: Staff gave patient a telephone number to call if patient had problems after leaving hospital.</p> <p>H-HL34: Staff told patient how to take care of self at home.</p> <p>H-HL35: Information from hospital staff about taking care of self at home was easy to understand.</p> <p>H-HL36: Patient received instructions in writing about how to take care of self at home.</p> <p>H-HL37: Written instructions about how to take care of self at home were easy to understand.</p> <p>H-HL38: Patient needed instructions about how to take care of self at home in a language other than English.</p> <p>H-HL39: Instructions about how to take care of self at home were available in patient's language.</p>
Cultural Competency Assessment Tool for Hospitals (CCATH)	<p>The Cultural Competency Assessment Tool for Hospitals (CCATH) is a survey designed to assess hospitals' adherence to the National CLAS Standards. The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups, and cognitive interviews. Exploratory and confirmatory factor analysis of the data supported 12 composite scales: clinical</p>

Measures	Items
(MEASURES BELOW: 12 scales)	cultural competency practices, human resources practices, diversity training, availability of interpreter services, interpreter services policies, quality of interpreter services, translation of written materials, leadership and strategic planning, performance management systems and quality improvement, data collection on inpatient population, data collection on service area, and community representation.
Clinical cultural competency practices	Does the hospital consider cultural and language needs during the discharge planning? (1b) Does the hospital accommodate the ethnic/cultural dietary preferences of inpatients? (1c) Does the hospital tailor patient educational materials for different cultural and language groups? (1d) Does the hospital tailor patient clinical assessments for different cultural and language groups? (1e)
Human resources practices	Which of the following benefits are available to staff? -Formal mentoring program (5a) -Management training (5b) -Tuition assistance or tuition reimbursement for ongoing education (5c) -Personal counseling or employee assistance programs (5d) -Flexible benefits, such as domestic partner benefits, family illness, death, and personal leave policies that accommodate alternative definitions of family (5e) -Affinity (networking) groups for racial/ethnic minority staff (5f) -Work/life balance programs, such as flex time, job-sharing or telecommuting, or child or elder care (5g)
Diversity training	Does this hospital have a formal and ongoing training program on cultural and language diversity? (9) Does the staff involved in the formal complaint and grievance process receive formal training in conflict resolution? (26a) Does the staff involved in the formal complaint and grievance process receive formal training about cultural or language differences? (26b)
Availability of interpreter services	Are interpreter services available for inpatients in Spanish? (12a) Are interpreter services available for inpatients in Chinese? (12b) Are interpreter services available for inpatients in Vietnamese? (12c) Are interpreter services available for inpatients in Korean? (12d) Are interpreter services available for inpatients in Tagalog? (12e)
Interpreter services policies	Does this hospital have a written policy and procedures about the use of bilingual staff as interpreters? (14a) Does this hospital have a written policy and procedures about the use of face-to-face professional interpreters? (14b) Does this hospital have a written policy and procedures about the use of face-to-face volunteer interpreters? (14c) Does this hospital have a written policy and procedures about the use of family or friends as interpreters? (14e)
Quality of interpreter services	Does this hospital include information on the availability of interpreter services in marketing and community outreach initiatives, such as television advertising, marketing brochures, and health fairs? (13) Does the hospital require an assessment of interpreter fluency in translating medical terms and procedures? (15a) Does the hospital require an assessment of interpreter accuracy and completeness? (15b)
Translation of written materials	What types of written materials does this hospital routinely provide to inpatients in languages other than English? -Informed consent statements? (17a) -Medication instructions? (17b) -Discharge planning instructions? (17c) -Patient advance directives? (17d)

Measures	Items
Leadership and strategic planning	<ul style="list-style-type: none"> -Health education material? (17e) -Does this hospital post signs providing directions in languages other than English? (19) Does this hospital's statement of strategic goals include specific language about recruitment of a culturally diverse workforce? (20a) Does this hospital's statement of strategic goals include specific language about retention of a culturally diverse workforce? (20b) Does this hospital's statement of strategic goals include specific language about the provision of culturally appropriate patient services? (20c) During the strategic planning process, does this hospital routinely assess achievement of its cultural diversity goals? (21) Is there a person, office, or committee who has dedicated responsibility for promoting this hospital's cultural diversity goals? (22a) Does this hospital report information to the community at least once per year about its performance in meeting the cultural and language needs of the service area? (27)
Performance management systems and QI	<ul style="list-style-type: none"> Does the employee satisfaction survey include measures of diversity climate? (8) Is the following assessment conducted at least once each year: <ul style="list-style-type: none"> -Accessibility of interpreter services? (23a) -Racial/ethnic differences in inpatient service use? (23b) -Racial/ethnic differences in inpatient assessments of care (satisfaction)? (23c)
Data collection on inpatient population	<ul style="list-style-type: none"> Does this hospital collect any ethnicity or racial data on individuals receiving inpatient services? (2) Does this hospital collect data on the preferred language for individuals receiving inpatient services? (3)
Data collection on service area	<ul style="list-style-type: none"> Does this hospital track changes in the race or ethnicity of its workforce? (6) Does this hospital collect or receive any of the following data on the population residing in the service area? <ul style="list-style-type: none"> -Race/ethnicity (24a) -Languages spoken (24b) -Income levels (24c) -Education levels (24d) -Health risk profiles (for diseases or conditions that disproportionately affect a particular racial/ethnic/gender group, such as African-American men, Latino women, or individuals of Jewish ethnicity) (24e) -Utilization of health screening services (mammograms, prostate screening exams, pap smears) (24f)
Community representation	<ul style="list-style-type: none"> Are community representatives routinely involved in the planning and design of inpatient services for culturally diverse populations? (25a) Are community representatives routinely involved in the evaluation of existing services for culturally diverse populations? (25b)
The Joint Commission Hospital Accreditation Standards and Elements of Performance (SELECTED MEASURES BELOW)	<p>Joint Commission standards are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organizational functions that are essential to providing safe, high-quality care. The Joint Commission's state-of-the-art standards set expectations for organizational performance that are reasonable, achievable, and surveyable. The Joint Commission has several accreditation standards that directly or indirectly support the provision of culturally and linguistically appropriate services. Here we highlight standards that support CLAS Standard 10.</p>

Measures	Items
The hospital compiles and analyzes data (PI.02.01.01)	EP 4: The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
The hospital improves performance on an ongoing basis (PI.03.01.01)	EP 11: For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following: <ul style="list-style-type: none"> - Patient experience and satisfaction related to access to care, treatment, or services and communication - Patient perception of the comprehensiveness of care, treatment, or services - Patient perception of the coordination of care, treatment, or services - Patient perception of the continuity of care, treatment, or services
The Joint Commission: 2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures (SELECTED MEASURES BELOW)	The Joint Commission categorizes its process performance measures into accountability and non-accountability measures. This approach places more emphasis on an organization's performance on <i>accountability measures</i> —quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement: research, proximity, accuracy, and adverse effects. Measures that meet all four criteria should be used for purposes of accountability (e.g., for accreditation, public reporting, or pay for performance). Those measures that have not been designated as accountability measures may be useful for quality improvement, exploration, and learning within individual health care organizations and are good advice in terms of appropriate patient care. The accountability measures cover areas including inpatient psychiatric services, venous thromboembolism (VTE) care, stroke care, perinatal care, immunization, tobacco treatment, and substance use. Here we highlight measures in VTE care and substance use.
Venous Thromboembolism (VTE) care	VTE-5 warfarin therapy discharge instructions
Immunization	IMM-2 16253 Influenza immunization
Substance use	SUB-1 16350 Alcohol use screening SUB-2 16351 Alcohol use brief intervention provided or offered 2014 SUB-3 16353 Alcohol and other drug use disorder treatment provided or offered at discharge 2014 SUB-4 16355 Alcohol and drug use: assessing status after discharge

Appendix E. Behavioral Health Measures

In developing the process and outcomes/impact measures described in Chapter Seven, we identified measures relevant to behavioral health settings. In Table E.1, we list examples of relevant measures identified, along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that a behavioral health organization or setting might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table E.2 provides additional detail for each measure and summarizes the relevant items that comprise each measure.

Table E.1. Behavioral Health Measures

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Experience of Care and Health Outcomes (ECHO) Survey	The Experience of Care and Health Outcomes (ECHO) Survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions about inpatient stays or self-help groups. The survey can be used for two types of organizations that are responsible for delivering behavioral health services: managed care organizations (MCOs) and managed behavioral healthcare organizations (MBHOs).	Patient experience	ECHO	See Table E.2 for list of measures.	ECHO Survey (AHRQ, 2016)
Disparity-sensitive measures or CLAS salient measures					
Alcohol screening and follow-up for people with serious mental illness	The percentage of patients ages 18 and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user	Primary prevention	NQF #2599 (measure steward: National Committee of Quality Assurance [NCQA])	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: “2599”)

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Initiation and engagement of alcohol and other drug dependence treatment	<p>Percentage of patients ages 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported:</p> <ol style="list-style-type: none"> 1. percentage of patients who initiated treatment within 14 days of the diagnosis. 2. percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. 	Effective communication and care coordination	NQF #4 (measure steward: NCQA)	This is a disparity-sensitive measure.	<p>NQF Quality Positioning System Measure Specifications (search: "4") (NQF, undated)</p> <p>National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities (NQF, 2008)</p>
Antidepressant Medication Management (AMM)	<p>The percentage of patients ages 18 and older with a diagnosis of major depression who were newly treated with antidepressant medication and who remained on an antidepressant medication treatment. Two rates are reported:</p> <ol style="list-style-type: none"> 1. effective acute phase treatment: the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks) 2. effective continuation phase treatment: the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months). 	Effective communication and care coordination	NQF #105 (measure steward: NCQA)	This is a disparity-sensitive measure.	<p>NQF Quality Positioning System Measure Specifications (search: "105") (NQF, undated)</p> <p>National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities (NQF, 2008)</p>
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric	This facility-level measure estimates an all-cause, unplanned, 30-day risk-standardized readmission rate (RSRR) for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Effective communication and care coordination	NQF #2860 (measure steward: Centers for Medicare & Medicaid Services [CMS])		<p>NQF Quality Positioning System Measure Specifications (search: "2860") (NQF, undated)</p> <p>SAMHSA National</p>

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
facility (IPF)					Behavioral Health Quality Framework Examples of Recommended Measures and Identified Gaps (SAMHSA, 2014b)

Table E.2. Behavioral Health Measures: Additional Details

Measures	Items
Experience of Care and Health Outcomes (ECHO) Survey (MEASURES BELOW: 5 composite and 17 individual measures)	The Experience of Care and Health Outcomes (ECHO) Survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions about inpatient stays or self-help groups. The survey can be used for two types of organizations that are responsible for delivering behavioral health services: managed care organizations (MCOs) and managed behavioral health care organizations (MBHOs).
Getting treatment quickly (composite)	Q3: Get help by telephone Q5: Get urgent treatment as soon as needed Q7: Get appointment as soon as wanted
How well clinicians communicate (composite)	Q11: Clinicians listen carefully Q12: Clinicians explain things Q13: Clinicians show respect Q14: Clinicians spend enough time Q15: Feel safe with clinicians Q18: Involved as much as you wanted in treatment
Getting treatment and information from the plan or MBHO (composite)	Q43: (MCO only) Getting clinician happy with Q39: (MBHO)/Q45 (MCO) Delays in treatment while waiting for plan approval Q46: (MCO only) Problem getting necessary treatment Q48: (MCO only) Understanding information about treatment in written materials or on the Internet Q41: (MBHO)/Q50 (MCO) Helpfulness of customer service Q52: (MCO only) Filling out paperwork
Perceived improvement (composite)	Q31: Compare ability to deal with daily problems to one year ago Q32: Compare ability to deal with social situations to one year ago Q33: Compare ability to accomplish things to one year ago Q34: Compare ability to deal with symptoms or problems to one year ago

Measures	Items
Information about treatment options (composite)	Q20: Told about self-help or consumer-run programs Q21: Told about different treatments that are available for condition
Rating of counseling and treatment	Q28: Overall rating of counseling and treatment
Rating of health plan (MCO only)	Q53: (MCO only) Overall rating of health plan
Office wait	Q10: Seen within 15 minutes of appointment time
Told about medication side effects	Q17: Told about side effects of medication
Including family and friends	Q19: Talk about including family and friends in treatment
Information to manage condition	Q22: Given as much information as wanted to manage condition
Patient rights information	Q23: Given information about rights as a patient
Patient feels he or she could refuse treatment	Q24: Patient feels that he or she could refuse a specific type of treatment
Privacy	Q25: Confident about privacy of treatment information
Cultural competency	Q27: Care responsive to cultural needs
Amount helped	Q29: Amount helped by treatment
Treatment after benefits are used up	Q37: (MBHO)/Q41 (MCO) Plan provides information about how to get treatment after benefits are used up

Appendix F. Public Health Measures

In developing the process and outcomes/impact measures described in Chapter Seven, we identified measures relevant to public health settings. In Table F.1, we list examples of relevant measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that a public health organization might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table F.2 provides additional detail for each measure and summarizes the relevant items that comprise each measure.

Table F.1. Public Health Measures

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services (CLAS) in Local Public Health Agencies (LPHAs)	This self-assessment tool for local public health agencies (LPHAs) aims to offer sound measures of culturally and linguistically appropriate services (CLAS). The term <i>LPHA</i> is defined as a publicly funded entity (i.e., local health department, local board of health, or other local government organization) responsible for providing essential public health services within a specific jurisdiction. The instrument consists of a director or designee interview protocol, a staffing questionnaire, and a client services questionnaire. Because the content among the three survey instruments greatly overlaps, not all items from each instrument are presented in this document. Listed in the appendix of COSMOS Corporation (2003) are items from the Client Services Questionnaire (consisting of four sections: quality monitoring and improvement, management information systems, translation and interpretation services, and other related client services and benefits) and select items from the director or designee interview protocol.	Culturally and linguistically appropriate services	Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies	Though a pilot test has been conducted on the self-assessment tools, measures have yet to be tested/validated. See Table F.2 for list of measures.	Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies – Final Report (COSMOS Corporation, 2003)

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey (CG-CAHPS)	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Clinician/Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.	Patient experience	CG-CAHPS	See Table F.2 for list of measures.	CAHPS Clinician/Group Survey (AHRQ, 2013b)
Disparity-sensitive measures or CLAS-salient measures					
Flu vaccinations for adults ages 18 and older	The percentage of adults ages 18 and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18–64 and 65 years of age and older.	Health and well-being	NQF #39 (measure steward: National Committee of Quality Assurance [NCQA])	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: “39”) (NQF, undated)
					Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Asthma emergency department visits	Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period	Chronic care management	NQF #1381 (measure steward: Alabama Medicaid Agency)	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: “1381”) (NQF, undated)

Measure(s)	Description	Area of Focus	Source/ID	Notes	Reference
					Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Depression screening by 18 years of age	The percentage of adolescents 18 years of age who had a screening for depression using a standardized tool	Health and well-being	NQF #1515 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF Quality Positioning System Measure Specifications (search: "1515") (NQF, undated)
					Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (NQF, 2012g)
Preventive care and screening: tobacco use: screening and cessation intervention	Percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Community/ population health	NQF #28 (measure steward: AMA-convened Physician Consortium for Performance Improvement)		NQF Quality Positioning System Measure Specifications (search: "28") (NQF, undated)

Table F.2. Public Health Measures: Additional Details

Measures	Items
Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services (CLAS) in Local Public Health Agencies (LPHAs)	This self-assessment tool for local public health agencies (LPHAs) is aimed to offer sound measures of culturally and linguistically appropriate services. The term <i>LPHA</i> is defined as a publicly funded entity (i.e., local health department, local board of health, or other local government organization) responsible for providing essential public health services within a specific jurisdiction. The instrument consists of a director or designee interview protocol, a staffing questionnaire, and a client services questionnaire. Because the content among the three survey instruments greatly overlaps, not all items from each instrument are presented in this document. Listed in the appendix of COSMOS Corporation (2003) are items from the Client Services Questionnaire (consisting of four sections: quality monitoring and improvement, management information systems, translation and interpretation services, and other related client services and benefits) and select items from the director or designee interview protocol. Please refer to the cited report for complete instruments, including survey questions and multiple-choice items (COSMOS Corporation, 2003)
(MEASURES BELOW)	
Director or designee telephone interview protocol (selected items)	<ol style="list-style-type: none"> 2. Does your local board of health or other governing body have a subcommittee or other group responsible for issues involving services provided to racial, ethnic, and linguistic minority groups? 3. Does your agency use community advisory boards or other similar entities to address community and client issues specifically related to the cultural and linguistic groups (represented by your clients)? 5. Does your agency conduct periodic needs assessments of community and/or clients' needs? 5a. Do these assessments include a component that specifically measures the need for culturally and linguistically appropriate services? 6a. Does your agency's plan include a component that improves the quality of services provided specifically to culturally and linguistically diverse clients? 7. Which of the following activities does your agency use to monitor the quality of culturally and linguistically appropriate services? 8. Is there a position in your agency specifically designated to promote and coordinate culturally and linguistically appropriate services? 9. Does your agency have a written policy governing language translation of written information for your clients? 11. Does your agency have a written policy governing interpretation services and assistance for your clients?
Client services questionnaire: quality monitoring and improvement	<ol style="list-style-type: none"> 1. Does your agency have a formal plan for collecting information on the quality of culturally and linguistically appropriate services provided to clients? 2. Which of the following activities are used to collect information on the quality of culturally and linguistically appropriate services? 3. For what purpose(s) does your agency collect this information? 4. Which of the following outcome data are collected in the quality improvement (QI) studies you conduct? 5. In which of the following ways are data from various QI studies used? 6. Does your agency conduct periodic assessments of community and/or clients' needs? 7. In which of the following ways does your state health department or local board of health support QI activities and needs assessments? 8. Does your agency have an internal working group or committee that coordinates, advises, or serves as a resource for planning and evaluation of services provided specifically to culturally and linguistically diverse groups? 9. Are provider and client information for performance assessments and QI activities linked?

Measures	Items
Client services questionnaire: management information systems (MIS)	<ol style="list-style-type: none"> 1. Does your agency's client information database record race and ethnicity? 2. Please report or estimate what percentage of your clients falls into the following racial groups. 3. Please report or estimate what percentage of your clients falls into the following ethnic groups. 4. Does your agency's client information database record the primary language spoken by each client? 5. Approximately what percentage of your clients speaks a primary language other than English? 6. In your agency's data systems, can client demographic information (such as race/ethnicity and language) be linked with other data (such as client satisfaction, grievances/complaints, and disenrollment)?
Client services questionnaire: translation and interpretation services	<ol style="list-style-type: none"> 1. Which of the following types of written materials are available to your clients in one or more languages other than English? 2. Which of the following activities are used to develop written materials in languages other than English? 3. Which of the following practices generally apply to the translations of written materials provided by your agency to its clients? 4. Which of the following entities provide review and/or approval of translated materials and products available to your clients? 5. Does your agency set and monitor targets or threshold levels for which vital documents and other written materials are translated to meet the language needs of your clients? 6. What methods are used by your agency to determine the need for translation of written materials into languages spoken by your clients? 7. Which of the following sources are used to determine the languages spoken by the populations served by your agency? 8. Which of the following methods are used to inform clients of the availability of translated documents and materials? 9. Is there a specific budget line in your agency for the allocation of funds to support translation of written documents and materials into languages spoken by your clients? 10. Which of the following interpretation services are available to your clients? 11. Which of the following characteristics apply to the language interpreters used by your agency? 12. Which of the following entities review and/or approve staffing and operation of interpretation services available to your clients? 13. Does your agency set and monitor targets or threshold levels for which interpretation services are systematically made available to meet the language needs of your clients? 14. What methods are used by your agency to determine the need for interpretation services? 15. Please provide the best estimate of how many employed, contracted, and certified medical interpreters are available to provide language assistance to your clients and staff? 16. At which of the following key entry or contact points does your agency provide interpretation services in languages other than English spoken by your clients? 17. Which of the following methods are used to inform clients of the availability of bilingual speakers and interpretation services in your agency? 18. Is there a specific budget line for the allocation of funds to support bilingual speakers and interpretation services in your agency? 19. For which of the following groups are translated materials and interpretation services generally made available by your agency?

Measures	Items
Client services questionnaire: other related client services	<ol style="list-style-type: none"> 1. Which of the following are provided or assured by your agency in an effort to be more culturally responsive to your clients? (Mark all that apply) 2. Which of the following complementary or alternative healing practices are offered to your clients? (Mark all that apply) 3. Which of the following kinds of information are available to your clients to promote the ability of your employed staff, contractors, and/or partnership members to serve culturally and linguistically diverse groups? (Mark all that apply) 4. Which of the following characteristics pertain to written materials available to your clients? (Mark all that apply) 5. Which of the following benefits have been achieved by your agency as a result of providing or assuring services that are responsive to the cultural and linguistic diversity of your clients? (Mark all that apply) 6. Which of the following factors present challenges for your agency in providing or assuring services that are responsive to the needs of culturally and linguistically diverse clients? (Mark all that apply)
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey (CG-CAHPS)	<p>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Clinician/Group Survey (CG-CAHPS) assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.</p>
Getting timely appointments, care, and information	<ul style="list-style-type: none"> • Patient got appointment for urgent care as soon as needed. • Patient got appointment for non-urgent care as soon as needed. • Patient got answer to medical question the same day he/she contacted provider's office.
How well providers communicate with patients	<ul style="list-style-type: none"> • Provider explained things in a way that was easy to understand. • Provider listened carefully to patient. • Provider showed respect for what patient had to say. • Provider spent enough time with patient.

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